2003

Certificate of Coverage for Active Employees

Self-Insured by the State of Washington

Effective January 1, 2003

Printed under the direction of the Washington State Health Care Authority Public Employee Benefits Board

HCA 54-550 (10/02)

Directory

If you have questions about …	Contact…
Medical/Surgical Issues	Uniform Medical Plan (UMP) Customer Service 1-800-762-6004 or 425-670-3000 (Seattle area), Monday-Friday, 8 a.m. to 6 p.m.
Appeals, First Level; Correspondence, Complaints, Preauthorization, Medical Review	Uniform Medical Plan P.O. Box 34578 Seattle, WA 98124-1578 Fax: 425-670-3197
Benefit Information, Certificates of Coverage, I.D. Cards, Claim Forms, Claims Status	Uniform Medical Plan P.O. Box 34850 Seattle, WA 98124-1850 *www.ump.hca.wa.gov*
Finding a Network Provider	For Services in: **Washington and Idaho border counties** of Bonner, Kootenai, Latah, and Nez Perce: 1-800-762-6004 or 425-670-3000 (Seattle area) or *www.ump.hca.wa.gov* **Oregon (Providence Preferred)**: 1-800-793-9338 or *www.providence.org/healthplans* **Other U.S. locations (Beech Street):** 1-800-432-1776 or *www.beechstreet.com*
Prescription Drugs **Member Services, Network Pharmacies, Formulary Questions**	Medco Health Solutions, Inc. 1-800-903-8224 Monday-Friday 4:30 a.m. to 10 p.m (PST), Saturday 5 a.m. to 5 p.m. (PST)
Appeals, First Level, Correspondence, Complaints (Non-Clinical)	Medco Health P.O. Box 721 Parsippany, NJ 07054 Phone: 1-800-903-8224
Appeals, First Level (Clinical), Drug Coverage Review and Preauthorization	Medco Health 5151 Blazer Pkwy, Ste B Dublin, OH 43107 Phone: 1-800-753-2851 Fax: 1-800-711-5673
Home Delivery (mail-order) Refills	Medco Health P.O. Box 3938 Spokane, WA 99220 *www.medcohealth.com*
Claims from Non-Network Pharmacies	Medco Health P.O. Box 2277 Lee's Summit, MO 64063-2277
Case Management	1-888-759-4855
Eligibility and Enrollment	PEBB Benefits Services 1-800-700-1555 or 360-412-2000 Fax: 360-923-2602 Monday-Friday, 8 a.m. to 5 p.m. *www.pebb.hca.wa.gov*
Preventive Care Guidelines	*www.ahcpr.gov/clinic/uspstf/uspstables.htm* *www.cdc.gov/nip/acip*
Tobacco Cessation	*Free and Clear* 1-800-292-2336 Monday-Friday, 8 a.m. to 6 p.m. *www.freeandclear.org/brochure*
Address Changes	Contact your personnel, payroll, or insurance office
Other Important Health Issues	Washington Hotline Numbers Alcohol and Substance Abuse 1-800-562-1240 Domestic Violence 1-800-562-6025 Emergency Contraception 1-888-668-2528 Family Planning 1-800-770-4334 HIV-AIDS (national) 1-800-342-2437 Poison control 1-800-732-6985

To obtain this booklet in another format (such as Braille or audio), call our Americans with Disabilities Act (ADA) Coordinator at 360-923-2805. TTY users (deaf, hard of hearing, or speech impaired), call 360-923-2701 or toll-free 1-888-923-5622.

To Learn More About... See Page...

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This booklet explains benefit provisions specific to the UMP and is the certificate of coverage for UMP enrollees. (This certificate of coverage supersedes previous certificates.)

If provisions in this booklet are inconsistent with any federal or state statute or rule, the language of the statute or rule will govern.

This booklet was compiled by the Washington State Health Care Authority/Uniform Medical Plan, PO Box 91118, Seattle, WA 98111-9218. If you have any questions about these provisions, please contact the UMP (see the Directory).

Highlights

Welcome to the Uniform Medical Plan (UMP)! This plan is designed to keep you and your family healthy in addition to providing benefits in case of illness or injury. As you know, your health care coverage can be one of your most important benefits. Please review this booklet carefully so that you can take advantage of all this plan has to offer.

UMP Features

Here are a few important plan features:

- When covered by the UMP, you can choose to see network, out-of-network, or non-network providers. These different options are described on pages 23-24, along with the coverage differences.
- Although you can select any provider, network providers offer several advantages:
  - Higher reimbursement rate
  - No claim forms for you to fill out
  - Your enrollee coinsurance applies to your annual medical/surgical out-of-pocket limit
  - Preventive care and preauthorized hospice services are covered at 100% of allowed charges
  - You're not responsible for differences between provider's billed charge and the UMP allowed charge
- Because the UMP network includes such a large number of physicians and other health care professionals, it's likely your current provider is already a network provider.
- The UMP allows you to self-refer for services from network, out-of-network, and non-network providers belonging to any approved provider type (see list beginning on page 26).
- All care must be medically necessary (as defined on page 85) to be covered.
- Enrolling in the UMP also gives you access to network pharmacies nationwide, where you can purchase retail prescription drugs at discounted rates—with no claim forms to worry about. You may also fill mail-order prescriptions through Medco Health Home Delivery Pharmacy Service™ (see pages 42-43 for details on your prescription drug benefits).
- Certain routine preventive services (such as screening mammograms, well-baby care, and certain routine physicals) are covered in full (you pay no coinsurance, copayments or deductible) when you use network providers. In addition, routine vision exams and hardware, required second opinions, and tobacco cessation services through *Free and Clear* are not subject to the annual medical/surgical deductible.
- Worldwide coverage for nonemergency and emergency care is a definite plus when you travel. Refer to "Your Medical/Surgical Provider Options, Out-of-Network Providers" on page 24 for specific information.

How to Use the Plan

- Review the UMP's online provider and pharmacy directories at www.ump.hca.wa.gov. If you don't have access to a computer, call UMP Customer Service at 1-800-762-6004 or 425-670-3000 in the Seattle area to request a copy.
- Choose a UMP network provider or UMP network pharmacy. Since network changes occur daily, when calling for an appointment ask if your provider is a UMP network provider. You may also call UMP to confirm your provider's status. Remember that UMP network providers are covered at a higher benefit level and give you other advantages as well.

The UMP is a self-insured preferred provider plan designed by the Public Employees Benefits Board (PEBB) and administered by the Washington State Health Care Authority (HCA).

***Provider** can refer to a person (a doctor or other health care professional) or a facility (such as a hospital, clinic, etc.)*

Network pharmacies offer not only a discounted price but also cap the amount you pay for certain retail prescription drugs. Network providers and network pharmacies offer you financial protection, because you cannot be billed for the difference between their billed charge and the UMP allowed charge.

- Identify yourself as a UMP enrollee when you make an appointment with a network provider.
- Present your UMP I.D. card when you receive health care services or have a prescription filled. When the UMP is the primary payer (see definition on page 86), the network provider or network pharmacy will submit the claim for you.
- See an out-of-network provider where there is no access to network providers, anywhere in the world! Please note that out-of-network providers can bill you for the difference between the UMP allowed charge and the provider's billed charge, in addition to UMP cost-sharing requirements (see page 24).
- You may choose to use a non-network provider if you like. If you do, your out-of-pocket expenses are greater, your enrollee coinsurance doesn't apply to your annual medical/surgical out-of-pocket limit, and you may be responsible for submitting your own claims to the UMP for reimbursement. Non-network providers can bill you for the difference between their billed charge and the allowed charge, in addition to UMP cost-sharing requirements (see page 24). Non-network pharmacies also will often cost you more, and you'll need to submit your own claim forms.
- Remember that some services require medical review/preauthorization, and some prescription drugs require review as well (see the sections starting on page 28 for details). This discourages unnecessary care, saves money for you and the UMP, and helps ensure the treatment and drugs you receive are necessary as well as appropriate. Although you're responsible for obtaining medical review/preauthorization and prescription drug review, your network provider or pharmacy may assist you with this process.

Your Rights and Responsibilities as a UMP Enrollee

To ensure the UMP offers the best possible medical care, we must work together with you and your providers as partners. To achieve this goal, you must first know your rights and responsibilities.

As a UMP enrollee, you have the *right* to:

- Be treated with respect
- Be informed by your providers or the UMP about all appropriate or medically necessary treatment options for your condition, regardless of cost or benefit coverage
- Have information about:
  - How new technology is evaluated for inclusion as a covered benefit
  - How providers are reimbursed by the UMP
  - Preauthorization and review requirements
  - Providers you select and their qualifications
  - The UMP and our network of providers
  - Your covered expenses, exclusions, and maximums/limits
- Keep your medical records and information about your care confidential
- Obtain a second opinion regarding your provider's care recommendations
- Make decisions in consultation with your providers about your health care

- Have a translator's assistance, if required, when calling UMP
- Receive:
  - All medically necessary covered services and supplies described in your *Certificate of Coverage*, subject to the maximums/limits, exclusions, deductibles, and enrollee coinsurance/copays
  - Clear information from your provider about illness or treatment before services and supplies are provided
  - Courteous, prompt answers from UMP
  - Timely, proper medical care without discrimination of any kind—regardless of health status or condition, sex, ethnicity, race, marital status, or religion
  - Written explanation from UMP regarding any request to refund an overpayment
- Voice complaints or initiate appeals about UMP services, decisions, or the care you receive.

As a UMP enrollee, you have the *responsibility* to:

- Comply with requests for information by the date given
- Follow your providers' instructions about your health care
- Give your providers complete information about your health to get the best possible care
- Keep your providers' phone numbers handy and know how to make or cancel an appointment as well as how to reach your providers after hours
- Know how to access emergency care
- Not engage in fraud or abuse in dealing with UMP or your providers
- Participate with your providers in making decisions about your health care
- Pay your copayments, coinsurance, or deductibles promptly
- Refund promptly any overpayment made to you or for you
- Report to UMP any outside sources of health care coverage or payment as well as any changes in your dependents or in your address
- Show the same respect to your providers and UMP as you expect from them
- Understand your UMP benefits, including what's covered, preauthorization and review requirements, and other information described in this *Certificate of Coverage*
- Use UMP network providers when available to help assure quality care at the lowest cost

Disclosure Information

We support the goal of giving you and your family the detailed information you need to make the best possible health care decisions. The following information can be found in this *Certificate of Coverage*:

- List of covered expenses (see pages 33-52)
- Benefit exclusions, reductions, and maximums/limits (see pages 53-57)
- Clear explanation of complaint and appeal procedures (see pages 63-66)
- Preventive health care benefits that are covered (see pages 45-50)
- Definition of terms (see pages 81-87)
- Our policy for protecting the confidentiality of health information (see pages 4-5)

Most of the following information is available on the UMP Web site at *www.ump.hca.wa.gov*. All may also be obtained on request, by calling UMP Customer Service at 1-800-762-6004.

- Annual accounting of all payments made by the UMP that have been counted against any payment limits, day limits, visit limits, or other limits on an enrollee's coverage
- Description and justification for provider compensation programs, including any incentives or penalties intended to encourage providers to withhold services
- Documents and other materials referred to in the PEBB open enrollment packet or this *Certificate of Coverage*
- General reimbursement or payment arrangements between the UMP and network providers
- How you can be involved in decisions about benefits
- List of network providers, including both primary care providers and specialists
- Plan list or formulary for prescription drugs, including policies regarding drug coverage and how drugs are added to or removed from the formulary
- Procedures to follow for consulting with providers
- Process for preauthorization/review
- Accreditation information, including measures used to report health plan performance such as consumer satisfaction survey results or Health Employer Data Information Set (HEDIS) measures
- Information on the UMP's disease management programs
- When the UMP may retrospectively deny coverage for preauthorized care

UMP does not prevent or discourage providers from informing you of the care you require, including various treatment options and whether, in the provider's view, that care is consistent with UMP's coverage criteria. You may, at any time, obtain health care outside of UMP coverage for any reason; however, you must pay for those services and supplies. In addition, the UMP does not prevent or discourage you from discussing the merits of different health care insurers with your provider.

Confidentiality of Personal Health Information

Personal health information includes:

- Health information relating to an enrollee's physical or mental condition, health history, or medical treatment
- Information collected during the enrollment process
- The record or file containing data pertaining to claims, complaints or appeals, or preauthorization/review
- Other personal information (such as marital status) acquired by UMP about enrollees

To protect the confidentiality of your personal health information while complying with applicable laws, regulations, and contract provisions regarding the use of enrollee-specific information, the UMP abides by the policy below.

Enrollee health information will be disclosed only with the consent or authorization of that enrollee or of someone authorized to give consent or authorization on the enrollee's behalf, as described in this statement or as required by law or court order.

UMP protects the privacy of personal health information from unauthorized or inappropriate use through:

- Employee orientation and confidentiality statements
- Electronic security
- Special written authorization from the enrollee when information is released outside the UMP
- Provider agreements requiring network providers to protect the confidentiality of enrollee personal health information

- Requirements that vendors and others must maintain confidentiality of enrollee personal health information
- Oversight by a Confidentiality Review Body under the UMP Quality Improvement Committee responsible for reviewing and updating this policy annually, and directing confidentiality practices regarding the collection, use, and disclosure of enrollee personal health information.

Under Chapter 70.02 RCW, personal information you may be required to submit to the UMP, including medical records, may not usually be disclosed without your express written consent or as provided by law. Other information submitted to or produced by the UMP is subject to the Health Care Authority's Public Records and Privacy Protections policy, which is available by calling 360-923-2822 or online at *www.hca.wa.gov*. Proprietary information (such as specific contract terms and conditions between the UMP and a particular provider or vendor) is not disclosable.

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The following sections describe the UMP and your benefits under the plan along with other details you'll need to use the plan effectively. If you have questions, see the Directory (inside front cover) for contact information.

Your Cost-Sharing Requirements

Annual Medical/ Surgical Deductible

A deductible is a dollar amount you must pay before the UMP will pay most benefits. The annual medical/surgical deductible is $200 per person and is calculated from January 1 to December 31, even if you're enrolled for only part of the year. (For example, a person enrolled in July would still have to pay the entire annual medical/surgical deductible for that year before the plan would reimburse for medical/surgical benefits, then would have to pay a new medical/surgical deductible beginning in January next year.)

The maximum annual medical/surgical deductible, payable by all family members combined under one subscriber's account, is $600 (for families of three or more covered persons). When a family's total annual medical/surgical deductible reaches this amount, no further medical/surgical deductible will be required for any family member during that calendar year.

Benefits Not Subject to the Annual Medical/ Surgical Deductible

The following services are exempt from the annual medical/surgical deductible—they will be paid according to their own reimbursement schedules, even if the annual medical/surgical deductible has not been met:

- Preventive care benefits listed on pages 45-50
- Required second opinions
- Routine eye exams and vision hardware
- Services received under the *Free and Clear* tobacco cessation program.

Annual Prescription Drug Deductible

The annual prescription drug deductible is $100 per person, calculated for prescriptions purchased from retail pharmacies and the Home Delivery (mail-order) option from January 1 to December 31. The maximum annual prescription drug deductible, payable by all members of a family combined under one subscriber's account, is $300 (for families of three or more covered persons). Like the annual medical/surgical deductible, you must meet your full $100 annual prescription drug deductible even if you enroll mid-year.

Medical/surgical services are subject to their own annual medical/surgical deductible, and do not apply to the annual prescription drug deductible.

Coinsurance

Coinsurance is the percent of allowed charges that UMP pays for medically necessary covered services; *enrollee* coinsurance is the percent you're required to pay (when the UMP pays less than 100%). See the "Summary of Benefits" charts on pages 10-21 for coinsurance levels.

Prescription drugs are subject to their own annual prescription drug deductible, and do not apply to the annual medical/surgical deductible.

Copayments

A copayment is a dollar amount you pay when receiving specific services, treatment, or supplies, such as inpatient hospitalization in a Washington and Oregon network facility, emergency room care, or Home Delivery (mail-order) drugs. See the "Summary of Benefits" charts on pages 10-21 for specific copayment requirements.

Annual Medical/Surgical Out-of-Pocket Limit

This out-of-pocket limit refers to the maximum total amount that you may be required to pay for most enrollee

An allowed charge that counts towards your annual deductible also counts toward any applicable benefit maximum/limit.

coinsurance and copayments each calendar year. Once your eligible enrollee coinsurance and copayment costs reach $1,125 per person or $2,250 per family (all family members combined under one subscriber's account), most medical/surgical claims from UMP network providers or out-of-network providers are paid at 100% of allowed charges for the remainder of the calendar year. The following costs are **not** counted towards your annual medical/surgical out-of-pocket limit:

- Annual medical/surgical and prescription drug deductibles
- Benefit reductions for failure to comply with medical review/preauthorization requirements
- Charges beyond benefit maximums, limits, and allowed charges
- Charges for expenses not covered
- Copayments for emergency room care
- Enrollee coinsurance/copayments for retail and Home Delivery (mail-order) prescription drugs
- Enrollee coinsurance/copayments for services from non-network providers.

Maximum Plan Payment

The total the UMP will pay for all benefits is a lifetime maximum of $1,000,000 per enrollee. Up to $10,000 of the lifetime maximum is restored automatically each January 1 for benefits paid by the UMP during the prior calendar year. Some services are also subject to specific calendar year or lifetime benefit limits, as detailed in the "Summary of Benefits" starting on page 9.

Summary of Benefits

This section summarizes your UMP benefits. To match our benefit structure, you'll notice that services are separated by those received ***inside*** Washington and Oregon (including four border counties of Idaho), and those received ***outside*** Washington and Oregon. The UMP covers only medically necessary services and supplies, as defined on page 85. Please refer to "Covered Expenses" as well as "Expenses Not Covered, Exclusions, and Limitations" for more details.

For any UMP benefit, once you have met the cost-sharing requirements, the plan pays at the levels shown on the following summary charts, subject to any benefit maximums or limits indicated. The percent paid by UMP refers to percent of the allowed charge only. The remaining amount of the allowed charge is your enrollee coinsurance (defined on page 83).

Only the *allowed charge* is covered—the maximum payment the UMP allows for a specific service or supply (see definition on page 81). In many cases, the UMP's allowed charge is less than the provider's billed charge for the service. If you use non-network or out-of-network providers, you may also be responsible for the difference between the provider's billed charge and the UMP allowed charge for the particular service (that is, in addition to the UMP cost-sharing requirements). *Network* providers have agreed to accept the UMP allowed charge as payment in full; *out-of-network* and *non-network* providers have not. See pages 23-24 for more information on your provider options.

Some services also have specific limits, as shown in the summary charts.

For Services Received *INSIDE* Washington and Oregon

Also includes services from network providers in the following Idaho counties: Bonner, Kootenai, Latah, and Nez Perce. However, services from other providers in these four counties are paid as out-of-network care (see page 13).

Benefits (subject to the annual medical/surgical deductible unless otherwise noted)	If you see a network provider, the plan pays	If you see a non-network provider, the plan pays**	Preauthorization required?	See page***
Acupuncture 16 treatments max/year	90%	60%	No	33, 53
Ambulance Air and ground	80%	80%	No	33, 53
Biofeedback (if for mental health diagnosis, see Mental Health benefit)	90%	60%	Yes	33, 39
Blood and Blood Derivatives	90%	60%	No, except stem cell harvesting for transplant purposes	34, 53
Bone, Eye, and Skin Bank Services	90%	60%	No	34
Cardiac and Pulmonary Rehabilitation	90%	60%	Yes	34
Chemical Dependency Treatment $11,285 max/24 months for inpatient and outpatient combined (excludes detox if you haven't been admitted to a chemical dependency program when those services received)				34, 87
• **Inpatient**	100% after $200 copay/day; $600 max copay/person/year	60%	No	
• **Outpatient**	90%	60%	No	
Dental Services (limited – does not include routine dental care, or most common dental services)	90%	60%	No, except surgical treatment of TMJ	34-35, 53
Diabetes Education	90%	60%	No	35, 54
Diagnostic Tests, Laboratory, and X-Ray (outpatient)	90%	60%	Certain services	35, 54

* Not subject to the annual medical/surgical deductible

** Your cost-share for these services does not count towards the annual medical/surgical out-of-pocket limit, and is exempt from that limit. See exception for out-of-network care on page 24.

*** Several exclusions listed in "Expenses Not Covered, Exclusions, and Limitations," may apply to all benefits. Please review the "Expenses Not Covered, Exclusions, and Limitations" section carefully.

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Benefits (subject to the annual medical/surgical deductible unless otherwise noted)	If you see a network provider, the plan pays	If you see a non-network provider, the plan pays**	Preauthorization required?	See page***
Dialysis	90%	60%	No	35
Durable Medical Equipment, Supplies, and Prostheses **Note:** For a wig or hairpiece to replace hair lost due to radiation or chemotherapy, $100 lifetime max	90%	60%	Yes, for rentals over 3 months and purchases over $1,000	36,54, 83
Emergency Room (ER) ER copay waived if admitted directly from ER; copay does not count toward the annual medical/surgical deductible or medical/surgical out-of-pocket limit	90% after $75** copay/visit	80% after $75** copay/visit	No	28, 36, 85
Hearing Care Hearing exam (routine) and resulting hearing aid; $400 max/36 months for routine exam and hearing aid combined	90%	60%	No	37, 54
Home Health Care	90%	60%	Yes	37, 54, 84
Hospice Care				37,54 56, 84
• **Inpatient**				
• When preauthorized	100%	60%	Yes	
• When not preauthorized	90%	60%	No	
• **Respite care** ($5,000 lifetime max)	100%	60%	Yes	
Hospital Services				
• **Inpatient**				38, 55
• Facility charges	100% after $200 copay/day; $600 max copay/person/year	60%	No. See "Physical, Occupational, Speech, and Massage Therapy" for exceptions	
• Professional services	90%	60%	No	
• **Outpatient**	90%	60%	No	38

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Benefits (subject to the annual medical/surgical deductible unless otherwise noted)	If you see a network provider, the plan pays	If you see a non-network provider, the plan pays**	Preauthorization required?	See page***
Mammograms				
• Screening mammograms (beginning at age 50, every one or two years)	100%	60%	No	35, 49
• Diagnostic mammograms	90%	60%	No	35
Mastectomy and Related Services	90%	60%	No	38
Mental Health Treatment				
• Inpatient: 10 days max/year	100% after $200 copay/day; $600 max copay/person/year	60%	No	26-28, 38-39, 55
• Outpatient: 20 visits max/year	90%	60% (Some provider types not covered; see pages 26-28 for specifics)	No	
Naturopathic Physician Services	90%	60%	No	39, 57
Neurodevelopmental Therapy (Age 6 years and under)				
• Inpatient: 60 days max/year	100% after $200 copay/day; $600 max copay/person/year	60%	No	39, 42, 55
• Outpatient: 60 visits max/year for all therapies combined	90%	60%	No, but treatment plan required	
Obstetric and Newborn Care				40
• **Inpatient**				
• Facility charges	100% after $200 copay/day; $600 max copay/person/year (Routine newborn nursery care is not subject to copay)	60%	No, except for birthing center	
• Professional services	90%	60%	No, except for limited-license obstetric provider	
• **Outpatient**	90%	60%	No	

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Benefits (subject to the annual medical/surgical deductible unless otherwise noted)	If you see a network provider, the plan pays	If you see a non-network provider, the plan pays**	Preauthorization required?	See page***
Office, Clinic, and Hospital Visits	90%	60%	No	40-41, 53, 55
Organ Transplants				41, 55
• **Inpatient**				
• Facility charges	100% after $200 copay/day; $600 max copay/person/year	60%	Yes	
• Professional services	90%	60%	Yes	
• **Outpatient** Donor search (bonemarrow, stem cell, umbilical cord) is limited to 15 searches per person, per transplant	90%	60%	Yes	
Out-of-Network Care	Not applicable	80%	Varies by service/supply	24, 86
Outpatient/Day Surgery, Ambulatory Surgical Center (ASC)	90%	60%	No	41, 57
Phenylkentonuria (PKU) Supplements	90%	60%	No	41
Physical, Occupational, Speech, and Massage Therapy				40, 42, 55-56
• Inpatient: 60 days max/year	100% after $200 copay/day; $600 max copay/person/year	60%	Yes	
• Outpatient: 60 visits max/year	90%	60%, except massage therapists not covered (see page 27)	No, but treatment plan required	

* Not subject to the annual medical/surgical deductible

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For Services Received *INSIDE* Washington and Oregon

Also includes services from network providers in the following Idaho counties: Bonner, Kootenai, Latah, and Nez Perce. However, services from other providers in these four counties are paid as out-of-network care (see page 13).

Benefits (subject to the annual medical/surgical deductible unless otherwise noted)	If you see a network provider, the plan pays	If you see a non-network provider, the plan pays**	Preauthorization required?	See page***
Prescription Drugs* (up to a 90-day supply)				24-26, 42-43, 53, 56-57
• **Retail**:** Annual prescription drug deductible applies. After you meet your annual prescription drug deductible, your cost-share limit for Tier 1 and Tier 2 drugs is: $50 per prescription for up to 30 days supply, $100 per prescription for 31-60 days supply, and $150 per prescription for 61-90 days supply. Limit does not apply to Tier 3 drugs and prescriptions purchased at non-network pharmacies.				
• **Tier 1:** Generic drugs, all insulin, and all disposable diabetic supplies	80% (enrollee coinsurance is 20% or cost-share limit, whichever is less)	80%	Certain drugs	
• **Tier 2:** Single-source *formulary* brand name drugs	70% (enrollee coinsurance is 30% or cost-share limit, whichever is less)	70%	Certain drugs	
• **Tier 3:** Single-source *nonformulary* brand name drugs, and all multi-source brand name drugs	50%	50%	Certain drugs	
• **Home Delivery** (mail-order)**: Annual prescription drug deductible applies. Copays will never exceed the cost of the medication.				
• **Tier 1**: Generic drugs, all insulin, and all disposable diabetic supplies	100% after $10 copay/refill	Not covered	Certain drugs	
• **Tier 2:** Single-source *formulary* brand name drugs	100% after $40 copay/refill	Not covered	Certain drugs	
• **Tier 3:** Single-source *nonformulary* brand name drugs, and all multi-source brand name drugs	100% after $80 copay/refill	Not covered	Certain drugs	
Preventive Care* See specific services covered	100%	60%	No	43-50, 53

* Not subject to the annual medical/surgical deductible

** Your cost-share for these services does not count towards the annual medical/surgical out-of-pocket limit, and is exempt from that limit. See exception for out-of-network care on page 24.

*** Several exclusions listed in "Expenses Not Covered, Exclusions, and Limitations," may apply to all benefits. Please review the "Expenses Not Covered, Exclusions, and Limitations" section carefully.

For Services Received *INSIDE* Washington and Oregon

Also includes services from network providers in the following Idaho counties: Bonner, Kootenai, Latah, and Nez Perce. However, services from other providers in these four counties are paid as out-of-network care (see page 13).

Benefits (subject to the annual medical/surgical deductible unless otherwise noted)	If you see a network provider, the plan pays	If you see a non-network provider, the plan pays**	Preauthorization required?	See page***
Radiation and Chemotherapy	90%	60%	No	51
Second Opinions				29, 51
• When required by UMP*	100%	100%	No	
• When optional	90%	60%	No	
Skilled Nursing Facility 150 days max/year	100% after $200 copay/day; $600 max copay/person/year	60%	Yes	51, 53, 57
Special Nursing Services $5,000 max/year	90%	60%	No	51, 56-57
Spinal and Extremity Manipulations 10 visits max/year	90%	60%	No	51, 55
Temporomandibular Joint (TMJ) Treatment (surgical)	90%	60%	Yes	51, 53
Tobacco Cessation Program* (*Free and Clear* program only) $250 lifetime max	90%	Not covered	No	51-52, 53-54, 56
During pregnancy and certain chronic medical conditions	100%	Not covered	No	
Vision Care*				52, 56, 57
• Eye exams (routine)—Once every two calendar years	90%	60%	No	
• Vision hardware, including frames, lenses, contact lenses, and fitting fee(s) combined	$100 max payment every two calendar years	$100 max payment every two calendar years	No	
Well-Baby Preventive Care Services* See specific services covered under "Preventive Care"	100%	60%	No	43-47, 53

* Not subject to the annual medical/surgical deductible

** Your cost-share for these services does not count towards the annual medical/surgical out-of-pocket limit, and is exempt from that limit. See exception for out-of-network care on page 24.

*** Several exclusions listed in "Expenses Not Covered, Exclusions, and Limitations," may apply to all benefits. Please review the "Expenses Not Covered, Exclusions, and Limitations" section carefully.

For Services Received *OUTSIDE* Washington and Oregon

Please see table on pages 10-15 for services in the following Idaho counties: Bonner, Kootenai, Latah, and Nez Perce.

Benefits (subject to the annual medical/surgical deductible unless otherwise noted)	If you see a network provider, the plan pays	If you see a non-network provider, the plan pays**	Preauthorization required?	See page***
Acupuncture 16 treatments max/year	80%	60%	No	33, 53
Ambulance Air and ground	80%	80%	No	33, 53
Biofeedback (if for mental health diagnosis, see Mental Health benefit)	80%	60%	Yes	33, 39
Blood and Blood Derivatives	80%	60%	No, except stem cell harvesting for transplant purposes	34, 53
Bone, Eye, and Skin Bank Services	80%	60%	No	34
Cardiac and Pulmonary Rehabilitation	80%	60%	Yes	34
Chemical Dependency Treatment $11,285 max/24 months for inpatient and outpatient combined (excludes detox if you haven't been admitted to a chemical dependency program when those services received)				34, 87
• **Inpatient**	80%	60%	No	
• **Outpatient**	80%	60%	No	
Dental Services (limited – does not include routine dental care, or most common dental services)	80%	60%	No, except surgical treatment of TMJ	34-35, 53
Diabetes Education	80%	60%	No	35, 54
Diagnostic Tests, Laboratory, and X-Ray (outpatient)	80%	60%	Certain services	35, 54

* Not subject to the annual medical/surgical deductible

** Your cost-share for these services does not count towards the annual medical/surgical out-of-pocket limit, and is exempt from that limit. See exception for out-of-network care on page 24.

*** Several exclusions listed in "Expenses Not Covered, Exclusions, and Limitations," may apply to all benefits. Please review the "Expenses Not Covered, Exclusions, and Limitations" section carefully.

For Services Received *OUTSIDE* Washington and Oregon

Please see table on pages 10-15 for services in the following Idaho counties: Bonner, Kootenai, Latah, and Nez Perce.

Benefits (subject to the annual medical/surgical deductible unless otherwise noted)	If you see a network provider, the plan pays	If you see a non-network provider, the plan pays**	Preauthorization required?	See page***
Dialysis	80%	60%	No	35
Durable Medical Equipment, Supplies, and Prostheses **Note:** For a wig or hairpiece to replace hair lost due to radiation or chemotherapy, $100 lifetime max	80%	60%	Yes, for rentals over 3 months and purchases over $1,000	36, 54, 83
Emergency Room (ER) ER copay waived if admitted directly from ER; copay does not count toward the annual medical/surgical deductible or medical/surgical out-of-pocket limit	80% after $75** copay/visit	80% after $75** copay/visit	No	28, 36, 85
Hearing Care Hearing exam (routine) and resulting hearing aid; $400 max/36 months for routine exam and hearing aid combined	80%	60%	No	37, 54
Home Health Care	80%	60%	Yes	37, 54, 84
Hospice Care				37, 54
• **Inpatient**				56, 84
• When preauthorized	100%	60%	Yes	
• When not preauthorized	80%	60%	No	
• **Respite care** ($5,000 lifetime max)	100%	60%	Yes	
Hospital Services				
• **Inpatient**				38, 55
• Facility charges	80%	60%	No. See "Physical, Occupational, Speech, and Massage Therapy" for exceptions	
• Professional services	80%	60%	No	
• **Outpatient**	80%	60%	No	38

* Not subject to the annual medical/surgical deductible

** Your cost-share for these services does not count towards the annual medical/surgical out-of-pocket limit, and is exempt from that limit. See exception for out-of-network care on page 24.

*** Several exclusions listed in "Expenses Not Covered, Exclusions, and Limitations," may apply to all benefits. Please review the "Expenses Not Covered, Exclusions, and Limitations" section carefully.

For Services Received *OUTSIDE* Washington and Oregon

Please see table on pages 10-15 for services in the following Idaho counties: Bonner, Kootenai, Latah, and Nez Perce.

Benefits (subject to the annual medical/surgical deductible unless otherwise noted)	If you see a network provider, the plan pays	If you see a non-network provider, the plan pays**	Preauthorization required?	See page***
Mammograms				
• Screening mammograms (beginning at age 50, every one or two years)	100%	60%	No	35, 49
• Diagnostic mammograms	80%	60%	No	35
Mastectomy and Related Services	80%	60%	No	38
Mental Health Treatment				26-28,
• Inpatient: 10 days max/year	80%	60%	No	38-39, 55
• Outpatient: 20 visits max/year	80%	60% (Some provider types not covered; see pages 26-28 for specifics)	No	
Naturopathic Physician Services	80%	60%	No	39, 57
Neurodevelopmental Therapy (Age 6 years and under)				39, 42, 55
• Inpatient: 60 days max/year	80%	60%	No	
• Outpatient: 60 visits max/year for all therapies combined	80%	60%	No, but treatment plan required	
Obstetric and Newborn Care				40
• **Inpatient**				
• Facility charges	80%	60%	No, except for birthing center	
• Professional services	80%	60%	No, except for limited-license obstetric provider	
• **Outpatient**	80%	60%	No	

* Not subject to the annual medical/surgical deductible

** Your cost-share for these services does not count towards the annual medical/surgical out-of-pocket limit, and is exempt from that limit. See exception for out-of-network care on page 24.

*** Several exclusions listed in "Expenses Not Covered, Exclusions, and Limitations," may apply to all benefits. Please review the "Expenses Not Covered, Exclusions, and Limitations" section carefully.

For Services Received *OUTSIDE* Washington and Oregon

Please see table on pages 10-15 for services in the following Idaho counties: Bonner, Kootenai, Latah, and Nez Perce.

Benefits (subject to the annual medical/surgical deductible unless otherwise noted)	If you see a network provider, the plan pays	If you see a non-network provider, the plan pays**	Preauthorization required?	See page***
Office, Clinic, and Hospital Visits	80%	60%	No	40-41, 53, 55
Organ Transplants				41, 55
• **Inpatient**				
• Facility charges	80%	60%	Yes	
• Professional services	80%	60%	Yes	
• **Outpatient** Donor search (bone marrow, stem cell, umbilical cord) is limited to 15 searches per person, per transplant	80%	60%	Yes	
Out-of-Network Care Geographic areas in which no network providers are available	Not applicable	80%	Varies by service/supply	24, 86
Outpatient/Day Surgery, Ambulatory Surgical Center (ASC)	80%	60%	No	41, 57
Phenylkentonuria (PKU) Supplements	80%	60%	No	41
Physical, Occupational, Speech, and Massage Therapy				40, 42, 55-56
• Inpatient: 60 days max/year	80%	60%	Yes	
• Outpatient: 60 visits max/year	80%	60%, except massage therapists not covered (see page 27)	No, but treatment plan required	

* Not subject to the annual medical/surgical deductible

** Your cost-share for these services does not count towards the annual medical/surgical out-of-pocket limit, and is exempt from that limit. See exception for out-of-network care on page 24.

*** Several exclusions listed in "Expenses Not Covered, Exclusions, and Limitations," may apply to all benefits. Please review the "Expenses Not Covered, Exclusions, and Limitations" section carefully.

For Services Received *OUTSIDE* Washington and Oregon

Please see table on pages 10-15 for services in the following Idaho counties: Bonner, Kootenai, Latah, and Nez Perce.

Benefits (subject to the annual medical/surgical deductible unless otherwise noted)	If you see a network provider, the plan pays	If you see a non-network provider, the plan pays**	Preauthorization required?	See page***
Prescription Drugs* (up to a 90-day supply)				24-26, 42-43, 53, 56-57
• **Retail**:** Annual prescription drug deductible applies. After you meet your annual prescription drug deductible, your cost-share limit for Tier 1 and Tier 2 drugs is: $50 per prescription for up to 30 days supply, $100 per prescription for 31-60 days supply, and $150 per prescription for 61-90 days supply. Limit does not apply to Tier 3 drugs and prescriptions purchased at non-network pharmacies.				
• **Tier 1:** Generic drugs, all insulin, and all disposable diabetic supplies	80% (enrollee coinsurance is 20% or cost-share limit, whichever is less)	80%	Certain drugs	
• **Tier 2:** Single-source *formulary* brand name drugs	70% (enrollee coinsurance is 30% or cost-share limit, whichever is less)	70%	Certain drugs	
• **Tier 3:** Single-source *nonformulary* brand name drugs, and all multi-source brand name drugs	50%	50%	Certain drugs	
• **Home Delivery** (mail-order)**: Annual prescription drug deductible applies. Copays will never exceed the cost of the medication.				
• **Tier 1**: Generic drugs, all insulin, and all disposable diabetic supplies	100% after $10 copay/refill	Not covered	Certain drugs	
• **Tier 2:** Single-source *formulary* brand name drugs	100% after $40 copay/refill	Not covered	Certain drugs	
• **Tier 3:** Single-source *nonformulary* brand name drugs, and all multi-source brand name drugs	100% after $80 copay/refill	Not covered	Certain drugs	
Preventive Care* See specific services covered	100%	60%	No	43-50, 53

* Not subject to the annual medical/surgical deductible

** Your cost-share for these services does not count towards the annual medical/surgical out-of-pocket limit, and is exempt from that limit. See exception for out-of-network care on page 24.

*** Several exclusions listed in "Expenses Not Covered, Exclusions, and Limitations," may apply to all benefits. Please review the "Expenses Not Covered, Exclusions, and Limitations" section carefully.

For Services Received *OUTSIDE* Washington and Oregon

Please see table on pages 10-15 for services in the following Idaho counties: Bonner, Kootenai, Latah, and Nez Perce.

Benefits (subject to the annual medical/surgical deductible unless otherwise noted)	If you see a network provider, the plan pays	If you see a non-network provider, the plan pays**	Preauthorization required?	See page***
Radiation and Chemotherapy	80%	60%	No	51
Second Opinions				29, 51
• When required by UMP*	100%	100%	No	
• When optional	80%	60%	No	
Skilled Nursing Facility 150 days max/year	80%	60%	Yes	51, 53 57
Special Nursing Services $5,000 max/year	80%	60%	No	51, 56-57
Spinal and Extremity Manipulations 10 visits max/year	80%	60%	No	51, 55
Temporomandibular Joint (TMJ) Treatment (surgical)	80%	60%	Yes	51, 53
Tobacco Cessation Program* (*Free and Clear* program only) $250 lifetime max	90%	Not covered	No	51-52 53-54, 56
During pregnancy and certain chronic medical conditions	100%	Not covered	No	
Vision Care*				52, 56, 57
• Eye exams (routine)—Once every two calendar years	80%	60%	No	
• Vision hardware, including frames, lenses, contact lenses, and fitting fee(s) combined	$100 max payment every two calendar years	$100 max payment every two calendar years	No	
Well-Baby Preventive Care Services* See specific services covered under "Preventive Care"	100%	60%	No	43-47, 53

* Not subject to the annual medical/surgical deductible

** Your cost-share for these services does not count towards the annual medical/surgical out-of-pocket limit, and is exempt from that limit. See exception for out-of-network care on page 24.

*** Several exclusions listed in "Expenses Not Covered, Exclusions, and Limitations," may apply to all benefits. Please review the "Expenses Not Covered, Exclusions, and Limitations" section carefully.

How the UMP Works

While you may receive coverage for services performed by any approved provider type (see list on pages 26-28), your out-of-pocket expenses will be less if you use a UMP network provider or network pharmacy. You'll be responsible only for any deductibles, enrollee coinsurance, and copayment along with expenses not covered (see the section starting on page 53), and charges that exceed benefit maximums/limits.

If you use an out-of-network provider or a non-network provider or pharmacy, you'll also be responsible for amounts that exceed the UMP allowed charge (defined on page 81), as well as any expenses not covered.

When UMP is the primary payer (see definition on page 86 and "If You Have Other Medical Coverage" on pages 67-68), network providers and network pharmacies will submit your claims and call to request any required medical review/preauthorization, saving you money on your share of the bill. If you use an out-of-network provider or a non-network provider or pharmacy, you may need to complete and submit the claim forms, you'll be responsible for obtaining any required medical review/preauthorization, and you may have to pay for services before you receive reimbursement from the UMP.

You and each covered dependent may choose different providers and decide whether or not to use UMP network providers and network pharmacies.

Your Medical/Surgical Provider Options

Medical/surgical provider options are described below:

Network Providers

Refers to providers who have contracted directly with the UMP (or are part of a network that has contracted with the UMP) to render services to UMP enrollees at a reduced rate. Network providers agree to accept the UMP allowed charge as payment in full for services covered by UMP. They cannot bill you for the difference between their billed charge and the UMP allowed charge. And using a network provider means you don't have to file claims. **Exception:** If you've met your benefit maximum/limit, network providers can bill their usual and customary charge.

For care in Washington, UMP directly contracts with a provider network that includes most acute care hospitals, nearly every major multispecialty clinic in the state, more than 10,000 physicians, and over 6,000 nonphysician health care professionals. We include additional alternative care providers (naturopaths, acupuncturists, and massage therapists) as network providers through an arrangement with the Alternáre network.

For care in the following four Idaho border counties—Bonner, Kootenai, Latah, and Nez Perce—UMP has some direct contracts with network providers. Other providers in these counties are considered out-of-network providers (see definition below), since the UMP network does not provide access to a full range of health care services.

For care in Oregon, access to network providers is through the Providence Preferred network.

For care elsewhere in the United States (other than Washington, Oregon, and the four Idaho counties identified above), access to network providers is through the Beech Street network, unless Medicare is your primary coverage.

See the summary tables starting on page 9 for the cost-sharing requirements that apply to services you receive from network providers. Your enrollee coinsurance (10% or 20%) for care from a network provider *does* apply to your annual medical/surgical out-of-pocket limit once your annual medical/surgical deductible has been met.

If Medicare is your primary coverage, the Beech Street network discounts are not available. Therefore, all services outside Washington, Oregon, and the Idaho counties of Bonner, Kootenai, Latah, and Nez Perce will be covered as out-of-network.

Preventive care and preauthorized hospice services are covered at 100% of allowed charges when you use network providers.

To locate a network provider in Washington State, you can access the UMP's online provider directory through the UMP Web site at *www.ump.hca.wa.gov,* or call UMP Customer Service at 1-800-762-6004 (425-670-3000 in the Seattle area) to request a printed copy.

For information on the Providence Preferred and Beech Street networks, see the Web sites and phone numbers listed on the inside cover of this booklet. Please be sure to use the Providence Preferred network directory only for care in Oregon, and the Beech Street network directory only for care outside Washington, Oregon, and the four Idaho counties named above. While Providence Preferred has arrangements with providers in Washington, and Beech Street has arrangements with providers in Washington, Oregon, and the four Idaho counties, these providers are not necessarily contracted with UMP and thus may not be UMP network providers.

Out-of-Network Providers

Refers to providers in U.S. locations with no access to network providers, as well as to all providers outside the U.S. In the Idaho counties of Bonner, Kootenai, Latah, and Nez Perce, providers who do not contract with UMP are considered *out-of-network* providers.

UMP's reimbursement rate is 80% of allowed charges, after your annual medical/surgical deductible has been met. Out-of-network providers can bill you for the difference between their billed charge and the UMP allowed charge (see definition on page 81). Your enrollee coinsurance (20%) for care from an out-of-network provider *does* apply to your annual medical/surgical out-of-pocket limit.

Out-of-network nonemergency services outside the U.S. must meet the UMP criteria explained under "Services Received Outside the U.S." on page 28.

Non-Network Providers

Refers to providers practicing in locations with access to network providers, but not contracted as a network provider. (In other words, these providers are in network provider service areas, where you could choose a network provider but decide not to.) See Idaho counties above for exception.

Non-network providers can bill you for the difference between their billed charge and the allowed charge.

UMP's reimbursement rate is 60% of allowed charges after your annual medical/surgical deductible has been met.

Your enrollee coinsurance (40%) for care from a non-network provider does **not** apply to your annual medical/surgical out-of-pocket limit.

Your Prescription Drug Provider Options

Although the prescription drug benefit differs based on whether drugs are purchased at a network or non-network pharmacy, it does not differ based on geographic location. And in addition to network and non-network retail pharmacies, you also have the choice of filling your prescriptions through our Home Delivery (mail-order) option. At either a retail pharmacy or through Home Delivery, you may receive up to a 90-day supply of medication, as prescribed by your physician.

Retail Pharmacies

The UMP contracts with network pharmacies through Medco Health Solutions, Inc. Network pharmacies, available nationwide, have agreed to provide retail prescription drugs at a discounted rate. Although you may use any pharmacy, a network pharmacy will save you time and money by collecting only your annual prescription drug deductible and applicable enrollee coinsurance at the point of sale, and

filing your claims for you. In addition, by using network pharmacies, you'll have the advantage of a cost-share limit on Tier 1 and Tier 2 drugs (see page 26).

At non-network pharmacies, you won't receive a discounted rate; the Tier 1 and Tier 2 cost-share limit doesn't apply; and you're required to pay the full cost of the prescription at the pharmacy, submit the claim yourself and wait for UMP reimbursement.

Transferring to a network pharmacy is easy. Just contact the network pharmacy, tell them you are a UMP enrollee and would like them to transfer your prescriptions from your current pharmacy. Be ready with the name and phone number of your current pharmacy as well as the prescription numbers or drug names and dosages. The UMP network pharmacy will do all the work.

At network and non-network retail pharmacies, you pay a coinsurance based on a percentage of the allowed charge for the prescription. The enrollee coinsurance varies according to the drug "tier" as described in the chart on page 26.

Home Delivery Pharmacy Service™ (mail-order)

The UMP also offers Home Delivery (mail-order) prescription drugs through Medco Health. After you meet the annual prescription drug deductible, you pay a fixed dollar amount copayment per prescription or refill, based on the applicable drug "tier" as described in the charts on page 26. You may receive up to a 90-day supply of medication, limited by the amount prescribed by your provider.

For information on how to order prescriptions by mail, see the Medco Health Web site at *www.medcohealth.com* or call 1-800-903-8224. You can also order refills online, or by phone.

The UMP does not recognize or contract with other Internet or mail-order pharmacies—only Medco Health.

Your Prescription Drug Benefit Amount

The amount you pay for prescriptions depends on whether a generic drug is available, and if not, whether the medication is on the UMP's prescription drug formulary. A formulary is a list of preferred drugs that have been identified as providing cost-effective treatment. Generic drugs have the same active ingredient as their brand name counterparts and are usually less expensive. Using generic and formulary drugs reduces costs both for you and for UMP. You may still choose nonformulary drugs or multi-source brand name drugs (brands that have generic alternatives), but you will generally pay more.

The UMP formulary offers a wide range of medications to choose from and is reviewed regularly by an independent group of practicing physicians and pharmacists to help ensure that the content is medically sound and supportive of your health. It is updated periodically, as new information and drugs become available.

See "Prescription Drugs, All Insulin, and All Disposable Diabetic Supplies" on pages 42-43 for details on both the retail and Home Delivery (mail-order) programs.

After you have met your annual prescription drug deductible, your cost-share for a prescription or refill is:

Tier (up to a 90-day supply)	Enrollee's cost at a network retail pharmacy	Enrollee's cost using Home Delivery service (mail-order)
Tier 1 Generic drugs, all insulin, and all disposable diabetic supplies	20% coinsurance or enrollee cost-share limit*, whichever is less	$10 copay or cost of drug, whichever is less
Tier 2 Single-source *formulary* brand name drugs	30% coinsurance or enrollee cost-share limit*, whichever is less	$40 copay or cost of drug, whichever is less
Tier 3 Single-source *nonformulary* brand name drugs, and all multi-source brand name drugs	50% coinsurance	$80 copay or cost of drug, whichever is less

*Enrollee cost-share limit for these prescriptions is $50 for up to a 30-day supply, $100 for a 31-60 day supply, and $150 for a 61-90 day supply. These limits do not apply to Tier 3 drugs or prescriptions filled at a non-network pharmacy.

Single-source brand name drugs are proprietary drugs that do not have generic equivalents since they are still under patent by the manufacturer. Multi-source brand name drugs are no longer under patent and have generic counterparts that have the same active ingredient(s).

To find out which specific drugs are listed on the UMP formulary, see the *UMP Prescription Drug Formulary Guide*. For additional information or updates, link to the formulary from the UMP Web site or call Medco Health at 1-800-903-8224.

See "Covered Expenses," starting on page 33, and "Summary of Benefits," starting on page 9 for more information on your prescription drug benefits.

Approved Provider Types

Only services performed by approved provider types are covered under the UMP. The list of approved provider types below includes individual medical professionals, hospitals and other facilities or organizations, pharmacies, and programs.

To bill the UMP directly and receive payment in accordance with UMP benefits, the provider must:

- Be of a type appearing on the approved provider list
- Have a current license, registration, or certificate to deliver services in their location
- Perform only services within the provider's scope of practice, as defined by the licensing agency
- Provide services within the UMP's benefit limits

"Approved" does not indicate whether a provider is network, out-of-network, or non-network.

Approved provider types include:

- Acupuncturists, licensed (LAc)
- Ambulatory Surgical Centers (ASC), licensed (Medicare-certified or JCAHO-accredited)
- Audiologists, certified

- Birthing centers, licensed
- Chiropractors, licensed (Doctors of Chiropractic [DC])
- Community mental health agencies, licensed; non-PhD psychologists and non-network or out-of-network counselors employed by these agencies are covered only when employed by and delivering services within a licensed community mental health agency *and* the agency bills for their services
- Counselors, licensed, including only UMP network Licensed Marriage and Family Therapists (LMFT), UMP network Licensed Masters of Social Work (LMSW), and UMP network Licensed Mental Health Counselors (LMHC)
- Dentists, licensed (Doctors of Dental Medicine [DMD] and Doctors of Dental Surgery or Dental Science [DDS]) (see pages 34-35 for limits on dental services covered)
- Diabetes education programs, Medicare-approved
- *Free and Clear* tobacco cessation program
- Hearing aid fitters and dispensers, licensed
- Home health aides, licensed (covered only when employed by and delivering services within a hospice or home health agency *and* that agency bills for their services)
- Home health or hospice agencies, licensed (Medicare-certified or JCAHO-accredited)
- Hospitals, licensed
- Massage practitioners, licensed (LMP); all massage practitioners must belong to the UMP provider network
- Midwife, licensed (LM)
- Naturopaths, licensed (Naturopathic Doctors [ND])
- Nurses, including Advanced Registered Nurse Practitioners (ARNP) and Certified Nurse Midwives (CNM) (all types must be licensed); see Practical Nurses, Registered Nurses, and Registered Nurse First Assistants (below)
- Occupational therapists, licensed (OT)
- Optometrists, licensed (Doctors of Optometry [OD])
- Pharmacists, registered (RPh) or Doctors of Pharmacy (PharmD)
- Physical therapists, registered and licensed (RPT)
- Physicians, licensed (Doctors of Medicine [MD] or Doctors of Osteopathic Medicine [DO])
- Physician Assistants, licensed (PA) (covered only when providing services under the supervision of a clinician and the clinician who is supervising bills for their services)
- Podiatrists, licensed (Doctors of Podiatric Medicine [DPM])
- Practical Nurses, licensed (LPN) (covered only when employed by and delivering services within a hospital, skilled nursing facility, hospice, home health agency, or under the direction of a clinician *and* the employing organization or clinician bills for their services)
- Psychologists, licensed (PhD)
- Registered Nurses, licensed (RN) (covered only when employed by and delivering services within a hospital, skilled nursing facility, hospice, home health agency, or under the direction of a clinician *and* the employing organization or clinician bills for their services)
- Registered Nurse First Assistants, certified and licensed (covered only when providing services under the supervision of a clinician and the clinician who is supervising bills for their services; only *Certified* Registered Nurse First Assistants are covered).

- Respiratory therapists, licensed (covered only when employed by and delivering services within a hospital, skilled nursing facility, hospice, home health agency, or under the direction of a clinician and the employing organization or clinician bills for their services)
- Skilled nursing facilities, licensed (Medicare-certified)
- Speech pathologists, certified by the American Speech, Language and Hearing Association
- Substance abuse treatment facilities, licensed (must be approved by UMP); non-PhD psychologists and out-of-network and non-network mental health counselors employed by these facilities are covered only when delivering services within an approved substance abuse facility *and* the facility bills for their services.

Services Received Outside the U.S.

Health care services may be covered outside of the U.S. as long as they:

- Are provided by an approved provider type
- Meet the definition of medically necessary
- Are appropriate for the condition being treated
- Are not considered to be experimental or investigational by United States standards, and
- Are covered by the UMP.

These services are generally covered at the out-of-network benefit level once the annual medical/surgical deductible has been satisfied.

If you are seeking nonemergency services abroad, UMP Medical Review staff can help you determine whether these services will be covered.

Foreign claims and any requested medical records must be translated into English with specific services, charges, drugs and dosage documented, along with the currency exchange rate.

Emergency Care

In cases of accidental injury or medical emergency, call 911 or seek care immediately. If a UMP network facility or provider is not available, you should obtain services from the most conveniently available approved provider. See the "Summary of Benefits" charts for coverage details.

Medical Review/ Preauthorization Requirements

The UMP includes a program to review and approve some medical services and supplies before, during, and after they're received. We have a medical review team to determine the appropriate treatment setting, whether the service or supply is medically necessary, and whether it is considered excessive. (The fact a service or supply is prescribed or furnished by an approved provider does not, by itself, make it medically necessary; see definition on page 85.)

This program discourages unnecessary care, saves money for you and the UMP, and helps ensure treatment is consistent with standards of good medical practice. Remember, you and your provider always make the final decision to proceed with, postpone, or cancel any admission, treatment, supply, or procedure.

All claims for hospital admissions are subject to retrospective review for medical necessity. Medical reviewers may approve a proposed admission, deny it and suggest alternative methods, or require a second opinion from another specialist.

The services listed that follow must be preauthorized by the UMP. Failure to obtain preauthorization prior to service may result in denial of your claim. To ensure you receive UMP benefits, call 1-800-762-6004 or 425-670-3000 in the Seattle area for preauthorization *before* receiving these services. Preauthorization requests may be faxed directly to the Medical Review Department at 425-670-3197.

- *Durable medical equipment, supplies, and prostheses*: Preauthorization is required for rentals beyond three months or for purchases over $1,000. The UMP will not pay for any additional costs determined noncovered, such as more costly equipment that serves the same medical purpose (for example, an electric wheelchair instead of a manual wheelchair).
- *Home health care:* Preauthorization is required for cases where visits are expected to exceed two hours a day or daily visits beyond 14 consecutive days. Call 1-888-759-4855 before starting home health services; otherwise, your claim will be denied if services are later determined not medically necessary or other home health care requirements are not met.
- *Hospice care:* Hospice care from UMP network providers is covered in full for up to six months when preauthorized.
- *Organ transplants:* All organ transplants (including bone marrow and stem cell transplants) require preauthorization. You also must be accepted into the treating facility's transplant program and follow the program's protocol.

Other services requiring preauthorization:

- Biofeedback
- Cardiac/pulmonary rehabilitation
- Cochlear implants
- Genetic testing (genetic testing unrelated to pregnancy is covered only when preauthorized and performed by a specialist center/provider designated by the UMP)
- Inpatient admissions for rehabilitation (physical, occupational, speech, and massage therapy)
- Obstetric services from limited-license providers such as midwives or naturopathic physicians or in a birthing center
- Positron Emission Tomography (PET) scans
- Skilled nursing facility admissions
- Surgical procedures generally performed for treatment of obesity (although obesity treatment is specifically excluded under the UMP, some procedures commonly performed for obesity may be considered for a covered medical condition)
- Temporomandibular joint (TMJ) surgery

"Summary of Benefits," "Covered Expenses," and "Expenses Not Covered, Exclusions and Limitations" contain more information on all services and supplies that require preauthorization.

It also may be to your benefit to request preauthorization on some frequently prescribed durable medical equipment (such as light boxes, CPAP/BiPAP, hospital beds, and breast pumps). This helps us address potential coverage issues in advance.

Obtaining an Estimate of Plan Benefits

Although only the services described in the previous section require preauthorization, you may want to confirm that the treatment you're considering is covered under the UMP, is medically necessary, and will be paid at a certain level.

To obtain an estimate of plan benefits, call the UMP. An estimate is not a guarantee of benefits; the actual benefits available to you are determined when you submit a claim, based on specific services received.

Second Opinions

The UMP's medical reviewers may require a second opinion before approving an admission or procedure. In this case, the second opinion will be paid at 100% of the allowed charge (for network, out-of-network, or in some cases non-network providers) and will not be subject to the annual deductible requirement. If you don't obtain a required second opinion, your benefits may be reduced by up to $200 or denied.

Optional Case Management

The UMP offers an optional case management service at no cost for medical/surgical cases involving complex treatment or high expenses. These cases are identified during the prenotification process, where hospitals notify the UMP if you are admitted for a diagnosis that may require case management services. Optional case management services are performed only with your knowledge and approval.

Required Case Management

To promote quality health care, the UMP medical director may in some cases review medical records and determine whether your use of any service is potentially harmful, excessive, or medically inappropriate. Based on this determination, UMP may require you to participate in and comply with a case management plan as a condition of continued benefit payment. Case management may include designating a primary physician (MD or DO) to coordinate care and designating a single hospital and pharmacy to provide covered services or medications. UMP has the right to deny payment for any services received outside of the required case management plan, except medically necessary emergency services.

You have the right to appeal the medical director's determination and the required case management plan through the process outlined under "Complaint and Appeal Procedures" on page 63.

Medical Review During Claim Processing

When claims are processed, UMP will verify that treatment was medically necessary and will review provider charges. This may require the submission of medical records. UMP reserves the right of final determination in the amount payable for any service or supply.

Prescription Drug Coverage Review and Preauthorization for Selected Drugs

Some medications are covered by UMP only for certain uses or in certain quantities. (For example, since UMP excludes cosmetic services and supplies, a drug will not be covered if used solely for cosmetic purposes meant to enhance physical appearance.) Also, the quantity may be limited to specific amounts over certain periods. In these cases, your doctor may need to provide more information to ensure coverage conditions are met.

Some drugs also may require a coverage review process for preauthorization or dosage limits. In addition, UMP may limit drugs to specific circumstances and protocols, or restrict initial and/or refill quantities where there is:

- Use outside the scope of this benefit
- A sound clinical basis
- Inadequate evidence of cost-effectiveness, or
- Evidence that cost-effectiveness is lacking

When you submit a prescription, the Medco Health Home Delivery service or your network retail pharmacy will let you know if more information is needed. You or the pharmacy can then ask your provider to call a special toll-free number. This call initiates a review that typically takes one to two business days. Once the review is complete, Medco Health will notify you and your provider of the decision. If you're not satisfied with the decision, you may appeal (see "Complaint and Appeal Procedures for Prescription Drugs" starting on page 65).

Prescription drugs listed below are subject to the coverage review process in certain situations. Check carefully whether the process applies to you or a family member by reviewing the specific criteria used to determine when coverage review is required. Note also that drugs may be added or removed from this list throughout the year:

- *COX-2 specific inhibitors (Celebrex®, Vioxx®, Bextra®, and others):* These will be covered only if you meet at least one of the following criteria:
  - Age 65 or older
  - Chronic use of nonsteroidal anti-inflammatory therapy including COX-2 inhibitors for 40 of the last 60 days
  - Use of anti-ulcer medication, medications that thin the blood, oral corticosteroids, or methotrexate.

When none of these criteria are met, coverage for the following drugs will be determined through Medco Health's coverage review process, and quantities will be limited.

- *Rheumatoid arthritis treatment (Enbrel®):* UMP coverage for Enbrel® will apply when the patient has responded inadequately to at least one disease-modifying anti-rheumatic drug in the past six months. Enbrel® will not be covered in other cases without review.
- *Peptic ulcer and gastroesophageal reflux disease treatment (Tagamet®, Zantac®, Axid®, Pepcid®, Prilosec®, Prevacid®, Protonix®, Nexium®, and Aciphex® and others):* First-time prescriptions will be filled at any prescribed dosage up to a 90-day supply. For subsequent prescriptions, because lower doses are generally effective at preventing ulcer recurrence, coverage of higher doses for these medications is limited to:
  - Gastroesophageal reflux disease or erosive esophagitis, when lower doses are ineffective
  - Peptic ulcer disease for H. pylori (an ulcer-causing organism) eradication
  - Preventing an ulcer due to chronic nonsteroidal anti-inflammatory drug use, when lower doses of anti-ulcer medications are ineffective
  - History of gastrointestinal bleeding
  - Gastric acid hypersecretory diseases
- *Migraine headache treatments (Amerge®, Axert®, Frova®, Imitrex®, Zomig®, Maxalt®, and Maxalt-MLT®):* Coverage is limited to quantities adequate to treat four headaches in 30 days, using any combination of these drugs. If you need a higher dosage, coverage will be determined through the review process.
- *Growth hormone treatments (Humatrope®, Nutropin®, Serostim®, Saizen®, Norditropin®, Genotropin®, Protopin®, and Geref®):* Coverage may be allowed for 3- to 12-month renewable periods following authorization through the review process. Pediatric or adult hormone deficiency and AIDS wasting syndrome are covered conditions.
- *Acne treatment (Retin-A®, Avita®, Altinac®, and tretinoin cream):* Patients from ages 10-30 do not have to go through the review process; all others do.

To find out whether a certain drug is subject to review, quantity limits, or other drug coverage review details, call Medco Health at 1-800-903-8224 or access the UMP Web site at *www.ump.hca.wa.gov*.

What to Do If Coverage Is Denied

If the retail pharmacy or Home Delivery (mail-order) service informs you that coverage is denied or limited, or the prescription is otherwise not covered in

full, you or your provider may contact Medco Health at 1-800-753-2851 to begin the prescription drug coverage review process. A written determination will be made and sent to you and your provider within approximately two business days after your doctor has contacted Medco Health with the information required to complete the coverage review.

If the medication is needed immediately, you may be eligible to receive a temporary supply during the review process. Ask your pharmacist to contact Medco Health at 1-800-753-2851 for approval of a temporary supply.

See "Prescription Drugs, All Insulin, and All Disposable Diabetic Supplies" on page 42 and "Complaint and Appeal Procedures" on page 65 for additional information and procedures related to prescription drug coverage.

Covered Expenses

UMP benefits are payable only for medically necessary services and supplies provided in accordance with applicable medical review/preauthorization requirements, except for emergency care or as described for coordination of benefits with other health plans. (See "If You Have Other Medical Coverage" on page 67.) Services must be received from a UMP approved provider type (see list on pages 26-28). All benefits are subject to the exclusions and limits shown in "Summary of Benefits" and "Expenses Not Covered, Exclusions, and Limitations" as well as in this section. Be sure to check "Definitions" for a description of most terms used in this *Certificate of Coverage*. Although the UMP strives to provide a full provider network in each geographic region, the fact services or supplies are listed does not necessarily mean network providers are available. Most services are subject to the annual medical/surgical deductible. For details on the deductible and the annual medical/surgical out-of-pocket limit, as well as enrollee coinsurance and other cost-sharing, see "How the UMP Works" and "Your Cost-Sharing Requirements."

As described in the "Summary of Benefits" charts and "How the UMP Works," your level of coverage depends on the provider you use and where you receive care.

The list of UMP covered expenses follows:

Acupuncture

This benefit covers acupuncture treatments or office visits to obtain acupuncture up to a combined total of 16 per calendar year. Acupuncture is covered only when used as an anesthetic or to reduce pain (not instead of surgery).

Ambulance

This benefit covers ambulance services for a life-threatening illness or injury, when other transport is not appropriate, to go:

- From the site of the medical emergency to the nearest facility equipped to treat a life-threatening illness or injury. See definition of medical emergency on page 85;
- From one facility to the nearest other facility equipped to give further treatment; or
- Home (if determined medically necessary).

Charges for regularly scheduled passenger air and rail transportation from the site of the medical emergency to the nearest facility equipped to provide the treatment are covered for the patient only—for one round trip per calendar year.

Ambulance services are reimbursed at 80% of the UMP allowed charge.

If ground ambulance services are not appropriate for transporting to the nearest facility, emergency air ambulance will be covered if the service meets the definition of medical emergency (page 85) and is the only appropriate method of transportation, based solely on UMP's determination of medical necessity.

Biofeedback Therapy

Biofeedback therapy requires preauthorization. If used to treat a physical medical condition, such as hypertension (high blood pressure), biofeedback therapy is covered at normal plan payment levels. If used for mental health treatment, biofeedback therapy is covered under the mental health payment provisions and subject to annual visit limits.

If you frequently travel outside the U.S., you may want to purchase individual insurance for air ambulance services, as the UMP covers this transportation only to the nearest facility equipped to provide the treatment needed. The fact you or your doctor prefer that you be transported to the facility nearest your home is not a consideration.

For more information on what isn't covered and benefit limits, see "Summary of Benefits" and "Expenses Not Covered, Exclusions, and Limitations."

Except when coverage is required by law, you will be liable for any services or supplies received after your UMP coverage ends.

Blood and Blood Derivatives

Blood and blood derivatives, including but not limited to synthetic factors, plasma expanders, and their administration, are covered.

Bone, Eye, and Skin Bank Services

Biologic materials supplied by human bone banks, eye banks, and skin banks are covered.

Cardiac and Pulmonary Rehabilitation

Cardiac and pulmonary rehabilitation that meet Medicare guidelines (not maintenance care) are covered when preauthorized.

Chemical Dependency Treatment

For more information on what isn't covered and benefit limits, see "Summary of Benefits" and "Expenses Not Covered, Exclusions, and Limitations."

This benefit covers inpatient and outpatient chemical dependency treatment and supporting services, up to a maximum of $11,285 every 24 consecutive months. Chemical dependency is defined as repetitive use of alcohol or drugs to the extent it interferes with social, psychological, or physical well-being. For purposes of this benefit, treatment and services are medically necessary if recommended in the "Patient Placement Criteria for the Treatment of Substance Abuse-Related Disorders II" as published in 2001 by the American Society of Addiction Medicine. Chemical dependency does not include dependence on tobacco, caffeine, or food. Covered expenses include:

- Inpatient prescription drugs prescribed in connection with chemical dependency treatment (all other prescription drug charges are paid according to the provisions under "Prescription Drugs, All Insulin, and All Disposable Diabetic Supplies," starting on page 42)
- Inpatient treatment according to a prescribed provider plan at a hospital or substance abuse treatment facility, subject to approval by the UMP's medical review program
- Outpatient substance abuse diagnosis and treatment

When the patient is not yet enrolled in a formal chemical dependency treatment program, medically necessary detoxification is covered as a medical emergency and is not included in calculating the dollar maximum benefit.

Dental Services

Routine and most other common dental services, including but not limited to dental extractions and aveoloplasties (regardless of the cause), are not covered as a UMP benefit (they may be covered by your PEBB dental plan). See excluded dental services on page 53.

General anesthesia and related facility charges are covered for any dental procedure performed in a hospital or ambulatory surgical center if the services are medically necessary because the enrollee:

- Is under the age of 7, or physically or developmentally disabled, with a dental condition that cannot be safely and effectively treated in a dental office, or
- Has a medical condition the physician determines would place the enrollee at undue risk if the procedure were performed in a dental office (the procedure must be approved by the patient's physician).

General anesthesia means services to induce a state of unconsciousness accompanied by a loss of protective reflexes, including the ability to maintain an airway independently and respond purposefully to physical stimulation or verbal command. Nitrous oxide is not reimbursable as general anesthesia.

Services of a dentist are covered *only* for the following:

- Excision of tumors or cysts of the jaw, cheeks, lips, tongue, gums, roof and floor of the mouth, or restorative surgery required by the excision
- Incision of salivary glands or ducts

- Obturator maintenance for cleft palate, gum reduction for gingival hyperplasia due to Dilantin/phenytoin, or jaw reconstruction due to cancer
- Preauthorized surgical treatment for temporomandibular joint (TMJ) conditions
- Reduction of a fracture or dislocation of the jaw or facial bones
- Repair of accidental injury to natural teeth, including evaluation of the injury and development of a treatment plan (evaluation and treatment plan must be completed within 30 days of the injury)

Diabetes Education

This benefit covers a Medicare-approved diabetes education program and follows Medicare protocol and criteria for:

- Newly diagnosed diabetics
- Diabetics whose treatment regimen is changed from diet control to oral diabetes medication, or from oral diabetes medication to insulin
- Diabetics with inadequate glycemic control as evidenced by an HbA1c level of 8.5% or more on two consecutive HbA1c determinations three or more months apart in the year before training begins
- Persons who are at high risk for complications based on inadequate glycemic control based on lack of feeling in the foot or other foot complications such as foot ulcers, deformities or amputation, preproliferative or proliferative retinopathy or prior laser treatment of the eye, or kidney complications related to diabetes

Services must be prescribed by an approved provider type.

Diagnostic Tests, Laboratory, and X-Rays

Positron Emission Tomography (PET) scans and genetic testing require preauthorization. In addition, genetic testing unrelated to pregnancy may be authorized only when performed by a specialist center/provider designated by the UMP.

This benefit covers:

- Diagnostic laboratory tests, x-rays (including diagnostic mammograms), and other imaging studies
- Electrocardiograms (EKG, ECG)
- Electroencephalograms (EEG) and similar tests
- Pathology exams
- Screening and diagnostic procedures during pregnancy and related genetic counseling for prenatal diagnosis of congenital disorders
- Studies and exams to establish a diagnosis or monitor the progress and outcome of therapy

These tests must be appropriate to the diagnosis or symptoms reported by the ordering provider.

Charges for Magnetic Resonance Imaging (MRI) are covered when determined medically necessary *and* appropriate to diagnose a specific condition.

Screening mammograms in conjunction with a covered routine physical exam (subject to U.S. Preventive Services Task Force guidelines) are covered under the preventive care benefit.

In cases of alternative diagnostic approaches with different fees, the UMP will cover the least expensive, medically reliable diagnostic method.

Electron Beam Tomography (EBT), self-referred or prescribed by your provider, is not covered.

Dialysis

Outpatient professional and facility services necessary for dialysis are covered when prescribed by an approved provider type to treat a covered condition. Independent dialysis facilities are covered at 80% of allowed charges. Dialysis facilities within a hospital setting are reimbursed based on the network, non-network, or out-of network status of the hospital.

For more information on what isn't covered and benefit limits, see "Summary of Benefits" and "Expenses Not Covered, Exclusions, and Limitations."

Durable Medical Equipment, Supplies, and Prostheses

Preauthorization regarding durable medical equipment for rentals more than three months or purchases over $1,000 is required.

This benefit covers services and supplies prescribed by an approved provider type to treat a covered condition, including:

- Artificial limbs or eyes (including implant lenses prescribed by a physician and required as a result of cataract surgery or to replace a missing portion of the eye)
- Breast pump for a medical condition of the mother or infant, such as a premature baby with difficulty sucking
- Casts, splints, crutches, trusses, and braces
- Contraceptive supplies that require a prescription, such as diaphragms
- Diabetes care equipment (nondisposable) such as glucometers, insulin injection aids, and insulin pumps as well as accessories
- Disposable diabetic supplies not purchased in a retail pharmacy or through the Medco Health Home Delivery (mail-order) pharmacy service
- Foot care appliances to prevent diabetes complications
- Initial external prosthesis and bra required by breast surgery and replacement of these items when necessitated by normal wear, a change in medical condition, or additional surgery (also see "Mastectomy and Related Services" on page 38)
- Ostomy supplies
- Oxygen and rental equipment for its administration
- Penile prosthesis when impotence is caused by a covered medical condition (not psychological), is a complication directly resulting from a covered surgery, or is a result of an injury to the genitalia or spinal cord *and* other accepted treatment has been unsuccessful
- Rental or purchase (at the UMP's option) of durable medical equipment such as wheelchairs, hospital beds, and respiratory equipment (combined rental fees cannot exceed full purchase price)
- Wig or hairpiece to replace hair lost due to radiation therapy or chemotherapy for a covered condition, up to a lifetime maximum of $100

Equipment charges in excess of the charge for less costly equipment that serves the same medical purpose are not covered. It may help you to request preauthorization for frequently prescribed durable medical equipment items such as light boxes, CPAP/BiPAP, hospital beds, and breast pumps. Otherwise, these claims are suspended for determination of medical necessity.

Note that durable medical equipment is covered at the network benefit rate only if you obtain the equipment or supply from a UMP network durable medical equipment supplier or other network provider.

Disposable supplies to treat diabetes and purchased at a retail pharmacy or through Medco Health's Home Delivery program are covered under the "Prescription Drugs, All Insulin, and All Disposable Diabetic Supplies" benefit starting on page 42.

For more information on what isn't covered and benefit limits, see "Summary of Benefits" and "Expenses Not Covered, Exclusions, and Limitations."

Emergency Room

This benefit is subject to a separate $75 copay per visit in addition to your enrollee coinsurance and annual medical/surgical deductible. It covers emergency room services for diagnosis and emergency treatment of a covered illness or injury. If the UMP determines emergency care is not medically necessary or could be rendered in a nonemergency setting with equal effectiveness, no benefits will be paid for emergency room services.

The emergency room copayment is waived if there is a direct hospital inpatient admission. However, the hospital inpatient services copayment or enrollee coinsurance will apply in these cases. See the "Summary of Benefits" for coinsurance/copayment details.

Hearing Care

This benefit is limited to $400 per enrollee in any 36 consecutive months. It covers:

- Hearing exams and evaluations related to the purchase of a hearing aid
- Purchase of a hearing aid (monaural or binaural) prescribed as a result of the exam/evaluation, including:
  - Ear mold(s)
  - Hearing aid instrument
  - Initial battery, cords, and other ancillary equipment
  - Warranty and follow-up consultation within 30 days after delivery of hearing aid
- Rental charges up to 30 days, if you return the hearing aid before actual purchase
- Repair of hearing aid equipment

To expedite claim payment for this benefit, submit the bills for the hearing exam and hearing aid purchase at the same time. Treatment for diseases/disorders of the ear or auditory canal (not related to a routine hearing exam) are covered as any other condition and not subject to the hearing care benefit limit.

Home Health Care

UMP preauthorization is required for home health care anticipated to exceed two hours a day or daily visits beyond 14 consecutive days. *Please call the UMP prior to the start of home health services in these cases.*

This benefit covers services provided and billed by a licensed home health agency to treat a covered illness or injury. Services must be part of a prescribed written treatment program. The provider must certify that you are homebound and that hospital or skilled nursing facility confinement would be required in the absence of home health care. Covered expenses include:

- Ancillary services such as intermittent (less frequently than daily visits, and under two hours per visit) home health aide and clinical social services, provided in conjunction with the skilled services of an RN, LPN, or physical, occupational, or speech therapist
- Disposable medical supplies as well as prescription drugs
- Home infusion therapy
- Visits for part-time or intermittent skilled nursing care and for physical, occupational, and speech therapy

Hospice Care (Including Respite Care)

If preauthorized, hospice care provided by network providers is covered at 100% of allowed charges. If not preauthorized, the normal UMP benefit will apply.

This benefit covers hospice care for a terminally ill enrollee for up to six months. The UMP may grant an extension if hospice care benefits have been exhausted. Services must be part of a written program of care by a state-licensed or Medicare-approved hospice.

The benefit includes:

- Inpatient services and supplies provided by the hospice when ordered by the attending provider such as prescription drugs, medical supplies normally used for inpatients, and rental of durable medical equipment
- Respite care for a homebound hospice patient (continuous care of more than four hours a day to give family members temporary relief from caring for the patient), which is covered up to a $5,000 lifetime maximum

For more information on what isn't covered and benefit limits, see "Summary of Benefits" and "Expenses Not Covered, Exclusions, and Limitations."

For more information on what isn't covered and benefit limits, see "Summary of Benefits" and "Expenses Not Covered, Exclusions, and Limitations."

Hospital Inpatient Services

Inpatient physical, occupational, speech, and massage therapy requires preauthorization.

This benefit covers hospital accommodation and inpatient services, supplies, equipment, and prescribed drugs to treat covered conditions, such as:

- Blood and blood derivatives
- Bone and eye bank services
- Diagnostic tests and exams
- General nursing care
- Prescription drugs administered during an inpatient stay
- Radiation and x-ray therapy
- Surgery
- Take-home prescription drugs dispensed and billed by the hospital upon discharge

When the hospital has only private rooms, the UMP will determine payment based on semiprivate room rates charged by other facilities in the area.

Special-care unit accommodations, such as in a cardiac, intensive care, or isolation unit, are covered based on the facility's special-care room rates.

Hospital Outpatient Services

This benefit covers services for outpatient surgery, day surgery, short-stay obstetrical services (discharged within 24 hours of admission), or observation services of less than 24 hours in addition to outpatient ancillary services such as lab, x-rays, radiation therapy, IV infusion therapy, and physical, occupational, and speech therapy.

Mastectomy and Related Services

This benefit covers restorative surgery necessitated by previous surgery covered under the UMP as well as mastectomy necessitated by disease, illness, or injury.

An enrollee receiving benefits in connection with a mastectomy who elects breast reconstruction in connection with the mastectomy is covered for:

- Reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses
- Physical complications of all stages of mastectomy, including lymphedemas

Mental Health Treatment

This benefit covers hospital inpatient and outpatient services as well as provider charges to treat neuropsychiatric, mental, or personality disorders, including eating disorders (bulimia and anorexia nervosa). Services from mental health providers for a mental health disorder are covered under this mental health treatment benefit, regardless of the cause of the disorder (such as postpartum depression).

Inpatient mental health treatment is limited to 10 days per calendar year. Outpatient mental health treatment is limited to 20 visits per calendar year. Visits for the sole purpose of medication management do not count toward the outpatient visit limit, and are instead covered as medical services.

As an alternative to inpatient care, the UMP covers partial hospitalization services. With preauthorization, partial hospitalization services may count toward inpatient benefit limits at a rate of two partial hospitalization days per inpatient day, until the 10-day limit on inpatient services has been met. Partial hospitalization services (see page 86) will be considered outpatient services for determining applicable enrollee coinsurance. If you reach the 10-day limit for inpatient services, or if you do not obtain preauthorization, partial hospitalization services will count toward the 20-visit limit for outpatient services.

Marital, family, and sexual counseling are not covered. However, services of a network marriage and family counselor are covered when provided to treat neuropsychiatric, mental, or personality disorders.

Biofeedback therapy is covered under this benefit when preauthorized and prescribed as part of an overall treatment plan for a mental health condition.

Mental health treatment must be provided or directed by one of the following:

- Licensed community mental health agency
- Licensed physician
- Licensed psychologist
- Nurse practitioner (ARNP) with training in psychology and counseling
- UMP network Licensed Master of Social Work, UMP network Licensed Mental Health Counselor, or UMP network Licensed Marriage and Family Therapist
- State hospital

Services from *non-network or out-of-network* Masters of Social Work, mental health counselors, or marriage and family therapists (or non-PhD psychologists) are covered under this benefit only when they are employed by and deliver services within a licensed community mental health agency *and* that agency bills for the services.

Mental Health Services and Your Rights

UMP and state law have established standards to:

- Help assure the competence and professional conduct of mental health service providers
- Support your right to receive treatment only after informed consent
- Protect the privacy of your medical information
- Enable you to know which services are covered under the UMP and the limits on your coverage

For a more detailed description of covered benefits for mental health services, or if you have a question or concern about any aspect of your mental health benefits, please contact the UMP.

If you would like to know more about your rights under the law, or if you think any mental health benefit you have received from the UMP may not conform to the terms of your coverage contract or your rights under the law, contact the UMP at 206-521-2000. If you have a concern about the qualifications or professional conduct of your mental health provider, call the Washington State Department of Health at 360-236-4902.

Naturopathic Physician Services

This benefit covers services of a naturopathic physician. Herbs and other nonprescription drugs, lotions, vitamins, or minerals prescribed as part of naturopathic care are not covered.

Neurodevelopmental Therapy (for Children Age 6 and Younger)

Children age 6 and younger are covered for neurodevelopmental therapy to assist with motor or sensory skill, such as speech therapy for developmental disorders of articulation, language therapy to correct developmental language delay, or diagnosis or treatment of learning disabilities. Benefits are payable only where significant deterioration in the child's condition would result without such services, or to restore and improve the child's functions.

Inpatient therapy is subject to the hospital inpatient copayment or enrollee coinsurance and limited to 60 days per calendar year. Outpatient care is covered

For more information on what isn't covered and benefit limits, see "Summary of Benefits" and "Expenses Not Covered, Exclusions, and Limitations."

up to 60 visits per calendar year for all therapies combined.

This benefit includes only the services of UMP approved provider types authorized to perform the therapy. Licensed massage practitioners must be UMP network providers to be covered. Services must be part of a formal written treatment plan developed in conjunction with the clinician diagnosing the condition and prescribing the therapy. The child is not eligible for both the "Physical, Occupational, Speech, and Massage Therapy" benefit and this benefit for the same services for the same condition, unless preauthorized by the UMP as a case management benefit exception.

Obstetric and Newborn Care

Preauthorization is required for the following services:

- Prenatal diagnostic screening for congenital disorders
- Services in a birthing center
- Services from limited-license providers, such as naturopathic physicians or midwives

This benefit covers services for pregnancy and its complications when provided and billed by a licensed physician, nurse practitioner, licensed midwife or certified nurse midwife, hospital, or birthing center. Services must be determined necessary and appropriate based on accepted medical practice by both the attending provider and the mother. To be covered, the provider must be able to perform the full scope of obstetric services (prenatal, delivery, and postnatal) except in areas where provider access is limited. Professional services include prenatal and postpartum care, prenatal testing, vaginal or cesarean delivery, and care of complications resulting from pregnancy. Hospital services are covered for obstetric care subject to the inpatient hospital copayment or enrollee coinsurance. Routine newborn nursery care will be covered during hospitalization of the mother receiving maternity benefits under this plan, and will not be subject to a separate copayment.

Newborn hospitalization for other than routine newborn care is covered subject to the hospital inpatient services copayment and/or enrollee coinsurance for the first 21 days from the date of birth, if the mother is covered by this plan.

Benefits for professional and other newborn follow-up care are also provided subject to any applicable deductible, copayment, or enrollee coinsurance amounts for the first 21 days from birth if the mother is covered by this plan. For newborn services beyond 21 days, the child must meet the plan's dependent eligibility as well as enrollment requirements, and any applicable premium must be paid.

Services related to voluntary and involuntary termination of pregnancy are covered.

For more information on what isn't covered and benefit limits, see "Summary of Benefits" and "Expenses Not Covered, Exclusions, and Limitations."

Office, Clinic, and Hospital Visits

This benefit covers visits to diagnose or treat covered conditions.

Family planning services (including contraceptive supplies requiring a prescription, or fitting or surgical implantation/insertion of contraceptive devices such as IUDs, cervical caps, and long-acting progestational agents) are covered as well.

This benefit also includes visits by the surgeon, assistant surgeon, and anesthesiologist in performing:

- Cosmetic, plastic, and reconstructive surgery, including related services and supplies, if necessary to improve or restore bodily function lost due to a nonoccupational accident occurring while you're covered, or a congenital anomaly (such as cleft palate or spina bifida) in a covered child
- Elective sterilization (tubal ligation and vasectomy)
- Limited dental services (see page 34)
- Mastectomy and related covered benefits (see page 38)

- Surgery for a covered condition
- Restorative surgery necessitated by previous surgery covered under the UMP

Organ Transplants

Preauthorization is required for organ transplants. This benefit covers services related to organ transplants (bone marrow and stem cell are considered organs for purposes of this benefit), including professional and facility fees for inpatient accommodation, diagnostic tests and exams, surgery, and follow-up care. Donor expenses are covered as defined below. Related services such as outpatient prescription drugs, and outpatient laboratory and x-rays may be covered under other UMP benefits.

Organ transplants will be covered when they are preauthorized, are performed in a plan-designated facility, and meet all of the following criteria:

- The service is required because of a disease, illness, or injury and is performed for the primary purpose of preventing, improving, or stabilizing the disease, illness, or injury.
- There is sufficient evidence to indicate that the service will directly improve the length or quality of the enrollee's life. Evidence is considered to be sufficient to draw conclusions if it is peer-reviewed (as defined by the National Association of Insurance Commissioners), is well-controlled, directly or indirectly relates the service to the length or quality of life, and is reproducible both within and outside of research settings.
- The service's expected beneficial effects on the length or quality of life outweigh its expected harmful effects.
- The service is a cost-effective method available to address the disease, illness, or injury. "Cost-effective" means there is no other equally effective intervention available and suitable for the enrollee which is more conservative or substantially less costly.

In addition, you must have been accepted into the treating facility's transplant program and continue to follow that program's protocol.

Costs to remove the organ from the donor and to treat complications directly resulting from the surgery are covered by the recipient's UMP coverage if the:

- Donor is not eligible for coverage under any other health care plan or government-funded program
- Organ recipient is enrolled in UMP
- Organ or tissue transplant meets the above coverage criteria

Benefit Limitations: Transplants are covered only if preauthorized and performed in a plan-designated facility (see definition on page 86). Coverage of direct medical costs for bone marrow, stem cell, and umbilical cord donor searches is limited to a combined total of 15 donor searches per person per transplant. No other benefits are provided for services related to locating an organ transplant donor.

For more information on what isn't covered and benefit limits, see "Summary of Benefits" and "Expenses Not Covered, Exclusions, and Limitations."

Outpatient/Day Surgery, Ambulatory Surgical Center

This benefit covers services for outpatient surgery, day surgery, services at an ambulatory surgical center (ASC), or short-stay obstetric services (discharged within 24 hours of admission). *A separate surgical suite/facility charge is not covered in some circumstances*. Although network providers cannot bill you for noncovered surgical suite/facility charges, you're responsible for these charges if billed by a non-network or out-of-network provider.

A doctor may be a network provider, yet perform services at a non-network day surgery/ASC. Be sure to confirm that the facility is in the UMP network.

Phenylketonuria (PKU) Supplements

Phenylketonuria (PKU) supplements are covered when prescribed and used to treat PKU.

For more information on what isn't covered and benefit limits, see "Summary of Benefits" and "Expenses Not Covered, Exclusions, and Limitations."

Physical, Occupational, Speech, and Massage Therapy

Inpatient physical, occupational, speech, and massage therapy must be preauthorized.

This benefit covers inpatient and outpatient services to improve or restore function lost due to an acute illness or injury, an exacerbation of a chronic injury, or a congenital anomaly (such as cleft lip or palate). Inpatient rehabilitation therapy services are covered to a maximum of 60 days per calendar year subject to the hospital inpatient copayment and/or enrollee coinsurance. If the UMP determines inpatient care is not medically necessary or could be received in an outpatient setting with equal effectiveness, no benefits will be paid for inpatient care. Outpatient therapy services are covered to a maximum of 60 visits per calendar year for all therapies combined.

Services must be part of a formal written treatment plan developed in conjunction with the clinician that diagnosed your condition and prescribed the therapy. Licensed massage practitioners must be UMP network providers to be covered.

The UMP will not cover the same services for the same condition under both this benefit and the "Neurodevelopmental Therapy" benefit unless preauthorized as a case management benefit exception.

Prescription Drugs, All Insulin, and All Disposable Diabetic Supplies

Although you can receive up to a 90-day supply of your prescription drug, the actual supply depends on the provider prescribing the medication. If your provider orders less than a 90-day supply, the pharmacist cannot give you more.

This benefit covers legend drugs (those that can be legally obtained only with a written prescription) including:

- Allergy antigens
- Chemotherapeutic agents for treatment of malignancies
- Contraceptive drugs
- Injections of certain prescription medications
- Methadone
- Prenatal vitamins (during pregnancy)

Certain nonprescription drugs and supplies are also covered including:

- All insulin and all disposable diabetic supplies such as test strips, lancets, and insulin syringes used in the treatment of diabetes
- Prenatal vitamins (during pregnancy)
- Nicotine replacement therapy (NRT) when recommended for participants in the *Free and Clear* tobacco cessation program

Insulin, prenatal vitamins, NRT, and disposable diabetic supplies are covered only when accompanied by a written prescription from an approved provider type.

To be covered, drugs must be prescribed and/or administered by a provider authorized by law to do so.

UMP prescription drug benefits are payable only for medically necessary medications and supplies. Services must be received from a licensed pharmacy employing registered pharmacists.

Both retail pharmacy and mail-order drugs through Medco Health Home Delivery are subject to the $100 annual prescription drug deductible.

For both retail and mail-order prescriptions, the amount you pay varies based on the following 3 drug "tiers" (categories):

Tier 1: Generic drugs, all insulin, and all disposable diabetic supplies

Tier 2: Single-source *formulary* brand name drugs

Tier 3: Single-source *nonformulary* brand name drugs ,and all multi-source brand name drugs

See "Your Prescription Drug Benefit Amount" and the "Summary of Benefits" for additional information on the tiers and specific cost-sharing requirements.

An FDA-approved drug used for off-label indications (that is, prescribed for a use other than its FDA-approved label) is covered only if recognized as effective for treatment:

- In a standard reference compendium (defined on page 87)
- In most relevant peer-reviewed medical literature (defined on page 86), if not recognized in a standard reference compendium
- By the federal Secretary of Health and Human Services

No benefits will be provided for any drug when the FDA has determined its use to be contraindicated.

Certain drugs may require preauthorization. In addition, the UMP may limit medications to specific circumstances and protocols or restrict initial and/or refill quantities where there is:

- A sound clinical basis
- Inadequate evidence of cost-effectiveness
- Evidence of lack of cost-effectiveness

See "Prescription Drug Coverage Review and Preauthorization for Selected Drugs" starting on page 30 for specific details.

You may receive up at a 90-day supply of medications either at a retail pharmacy, or through Home Delivery (the UMP's mail order pharmacy option), unless otherwise limited by the amount authorized by your prescriber, drug coverage review, preauthorization requirements, plan exclusions or limits, or drug availability.

See "Your Prescription Drug Provider Options" on pages 24-25 for more information on your choice of pharmacies.

If your provider allows substitution on your prescription for a multi-source brand name drug with a generic equivalent, under Washington State law the pharmacist will substitute the generic drug, if available, resulting in lower out-of-pocket expense to you.

Home Delivery (Mail-Order) Prescription Drugs

You may order drugs by mail, using the Medco Health Home Delivery pharmacy service. You may receive up to a 90-day supply of the medication, applying the same annual prescription drug deductible, preauthorization requirements, and limits as for retail prescription drugs.

Prescriptions mailed or orders placed year-end, but not processed until January 1 or after, will be subject to the annual prescription drug deductible applicable on the date the prescription is processed.

If there is a manufacturer shortage of a specific drug (or other shortage that Medco Health cannot control), and the quantity available is less than the quantity you ordered, the copayment will not be prorated. The original copayment applicable for up to a 90-day supply is charged.

Preventive Care

This benefit is not subject to the annual medical/surgical deductible. It covers the services in the tables that follow.

The benefit structure for well-baby care and routine physical exams for children and adults, including immunizations, was designed with input from the U.S. Preventive Services Task Force as well as the National Immunization Program of the Centers for Disease Control and Prevention, and recently published peer-reviewed literature on preventive care.

For more information on what isn't covered and benefit limits, see "Summary of Benefits" and "Expenses Not Covered, Exclusions, and Limitations."

Services are provided on an outpatient basis specifically to monitor and maintain health and to prevent illness.

Persons with specific chronic medical conditions and pregnant women can also receive tobacco cessation treatment through the *Free and Clear* Program under the preventive care benefit, when preauthorized.

If you receive preventive services that exceed those listed here, they will not be reimbursed under the UMP's preventive care benefit. Instead, when medically necessary they will be reimbursed under the specific benefit the charges apply to (such as diagnostic tests, or laboratory and x-rays) and will be subject to the annual medical/surgical deductible. If your provider does not bill for a routine physical exam code and

instead documents a diagnosis on your claim, coverage is provided under the specific benefit.

When the preventive care tables that follow show the recommended frequency of service as once a year, annually, or every one to three years, coverage will not be provided sooner than once every 12 consecutive months. Preauthorization to waive this requirement may be requested by describing your individual circumstances to the UMP in writing.

When services are received from a UMP network provider, the specified preventive care coverage is provided at 100% of allowed charges (no deductible, coinsurance or copayments).

For more information on what isn't covered and benefit limits, see "Summary of Benefits" and "Expenses Not Covered, Exclusions, and Limitations."

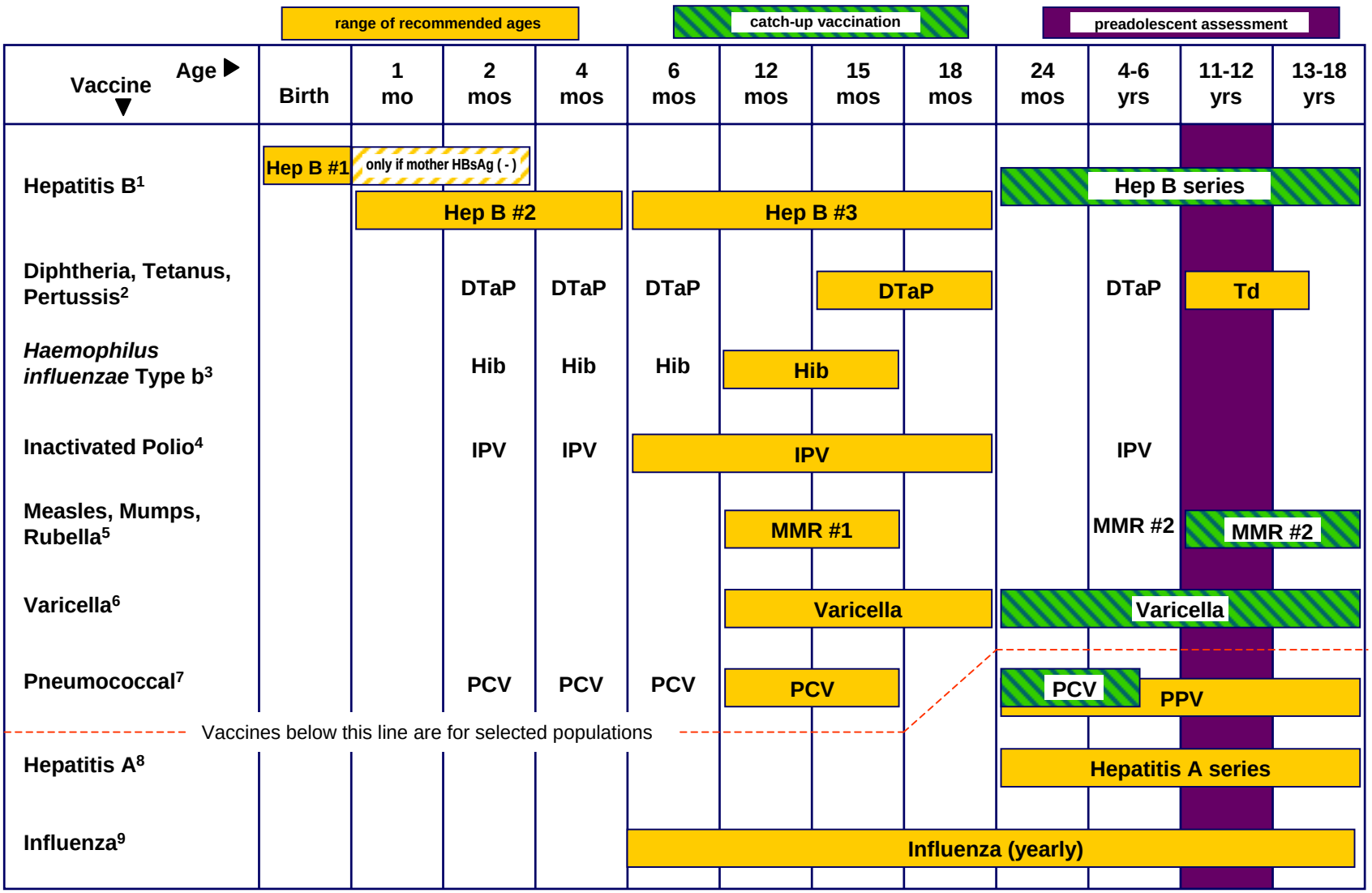
Preventive Care

Children: Birth–23 months	
Screening exams	
Age	**Service covered**
2-4 days	Preventive health visit or home health visit, if your baby was discharged early
10-14 days	Preventive health visit
2 months	Preventive health visit
4 months	Preventive health visit
6-9 months	Preventive health visit with hemoglobin/hematocrit
10-13 months	Preventive health visit with lead screening if child at risk
14-18 months	Preventive health visit
Children: Ages 2-6 years	
Screening exams	
Age	**Service covered**
2-3 years	Preventive health visit
3-4 years	Vision screening by pediatrician
4-6 years	Preventive health visit, including blood pressure
Children: Ages 7-18 years	
Screening exams	
Age	**Service covered**
7-9 years	Preventive health visit
10-12 years	Preventive health visit
13-15 years	Preventive health visit
16-18 years	Preventive health visit
18 years	Females: Pap smear and chlamydia screening (earlier if sexually active)

For more information on what isn't covered and benefit limits, see "Summary of Benefits" and "Expenses Not Covered, Exclusions, and Limitations."

The graph and explanation on the following pages represent the immunization schedule for children from birth to age 18 recommended by the National Immunization Program of the Centers for Disease Control and Prevention.

Recommended Childhood Immunization Schedule
United States, 2002



This schedule indicates the recommended ages for routine administration of currently licensed childhood vaccines, as of December 1, 2001, for children through age 18 years. Any dose not given at the recommended age should be given at any subsequent visit when indicated and feasible. Indicates age groups that warrant special effort to administer those vaccines not previously given. Additional vaccines may be licensed and recommended during the year. Licensed combination vaccines may be used whenever any components of the combination are indicated and the vaccine's other components are not contraindicated. Providers should consult the manufacturers' package inserts for detailed recommendations.

Approved by the Advisory Committee on Immunization Practices (www.cdc.gov/nip/acip) the American Academy of Pediatrics (www.aap.org), and the American Academy of Family Physicians (www.aafp.org).

Footnotes: Recommended Childhood Immunization Schedule United States, 2002

1. Hepatitis B vaccine (Hep B). All infants should receive the first dose of hepatitis B vaccine soon after birth and before hospital discharge; the first dose may also be given by age 2 months if the infant's mother is HBsAg-negative. Only monovalent hepatitis B vaccine can be used for the birth dose. Monovalent or combination vaccine containing Hep B may be used to complete the series; four doses of vaccine may be administered if combination vaccine is used. The second dose should be given at least 4 weeks after the first dose, except for Hib-containing vaccine which cannot be administered before age 6 weeks. The third dose should be given at least 16 weeks after the first dose and at least 8 weeks after the second dose. The last dose in the vaccination series (third or fourth dose) should not be administered before age 6 months.

Infants born to HBsAg-positive mothers should receive hepatitis B vaccine and 0.5 mL hepatitis B immune globulin (HBIG) within 12 hours of birth at separate sites. The second dose is recommended at age 1-2 months and the vaccination series should be completed (third or fourth dose) at age 6 months.

Infants born to mothers whose HBsAg status is unknown should receive the first dose of the hepatitis B vaccine series within 12 hours of birth. Maternal blood should be drawn at the time of delivery to determine the mother's HBsAg status; if the HBsAg test is positive, the infant should receive HBIG as soon as possible (no later than age 1 week).

2. Diphtheria and tetanus toxoids and acellular pertussis vaccine (DTaP). The fourth dose of DTaP may be administered as early as age 12 months, provided 6 months have elapsed since the third dose and the child is unlikely to return at age 15-18 months. **Tetanus and diphtheria toxoids (Td)** is recommended at age 11-12 years if at least 5 years have elapsed since the last dose of tetanus and diphtheria toxoid-containing vaccine. Subsequent routine Td boosters are recommended every 10 years.

3. *Haemophilus influenzae* type b (Hib) conjugate vaccine. Three Hib conjugate vaccines are licensed for infant use. If PRP-OMP (PedvaxHIB® or ComVax® [Merck]) is administered at ages 2 and 4 months, a dose at age 6 months is not required. DTaP/Hib combination products should not be used for primary immunization in infants at age 2, 4 or 6 months, but can be used as boosters following any Hib vaccine.

4. Inactivated poliovirus vaccine (IPV). An all-IPV schedule is recommended for routine childhood poliovirus vaccination in the United States. All children should receive four doses of IPV at age 2 months, 4 months, 6-18 months, and 4-6 years.

5. Measles, mumps, and rubella vaccine (MMR). The second dose of MMR is recommended routinely at age 4-6 years but may be administered during any visit, provided at least 4 weeks have elapsed since the first dose and that both doses are administered beginning at or after age 12 months. Those who have not previously received the second dose should complete the schedule by the visit at age 11-12 years.

6. Varicella vaccine. Varicella vaccine is recommended at any visit at or after age 12 months for susceptible children (i.e. those who lack a reliable history of chickenpox). Susceptible persons aged $\geq$ 13 years should receive two doses, given at least 4 weeks apart.

7. Pneumococcal vaccine. The heptavalent **pneumococcal conjugate vaccine (PCV)** is recommended for all children aged 2-23 months and for certain children aged 24-59 months. **Pneumococcal polysaccharide vaccine (PPV)** is recommended in addition to PCV for certain high-risk groups. See *MMWR* 2000;49(RR-9);1-37.

8. Hepatitis A vaccine. Hepatitis A vaccine is recommended for use in selected states and regions, and for certain high-risk groups; consult your local public health authority. See *MMWR* 1999;48(RR-12);1-37.

9. Influenza vaccine. Influenza vaccine is recommended annually for children age $\geq$ 6 months with certain risk factors (including but not limited to asthma, cardiac disease, sickle cell disease, HIV and diabetes; see *MMWR* 2001;50(RR-4);1-44), and can be administered to all others wishing to obtain immunity. Children aged ≤12 years should receive vaccine in a dosage appropriate for their age (0.25 mL if age 6-35 months or 0.5 mL if aged ≥ 3 years). Children aged ≤ 8 years who are receiving influenza vaccine for the first time should receive two doses separated by at least 4 weeks.

Additional information about vaccines, vaccine supply, and contraindications for immunization, is available at www.cdc.gov/nip or at the National Immunization Hotline, 800-232-2522 (English) or 800-232-0233 (Spanish).

Preventive Care

Men: Ages 19 Years and Older	
Screening exams	
Age	**Service covered**
19-64 years	Preventive health visit every 1-3 years
35-65 years	Blood cholesterol/lipids screening every 5 years
50+ years	Fecal occult blood home test for colorectal cancer at each preventive health visit
50+ years	Flexible sigmoidoscopy once every 48 months; colonoscopy once every 10 years, but not within 48 months of screening sigmoidoscopy
50+ years	PSA (Prostate Specific Antigen) once a year
65+ years	Preventive health visit once a year
Immunizations	
Age or other indications	**Service covered**
19+ years	**Tetanus/Diptheria (Td) booster** once every 10 years
19+ years	**Varicella** (if no history of chickenpox and not previously immunized)
40 years	**Measles/Mumps/Rubella (MMR)** second dose if not administered previously
50+ years (or younger with chronic illness)	**Influenza vaccine**, annually
65+ years (or younger with chronic illness)	**Pneumococcal vaccine**—once; plus one-time revaccination five years later for patients with chronic illness or post-splenectomy patients

Women: Ages 19-39	
Screening exams	
Age	**Service covered**
19-39 years	Preventive health visit every 1-3 years
20-39 years	Breast exam by provider with self-exam instructions during preventive health visit
19-39 years	Pelvic exam every 1-3 years
19-39 years	Pap smears every 1-3 years after 3 yearly normal results and chlamydia screening through 24 years

For more information on what isn't covered and benefit limits, see "Summary of Benefits" and "Expenses Not Covered, Exclusions, and Limitations."

Immunizations	
Age or other indications	**Service covered**
19-39 years	**Tetanus/Diptheria (Td) booster** once every 10 years
19-39 years	**Varicella** (if no history of chickenpox and not previously immunized)
Childbearing age, but not during pregnancy	**Measles/Mumps/Rubella (MMR)** second dose (discuss with provider)
Chronic illness	**Influenza vaccine**, annually
Chronic illness or post-splenectomy	**Pneumococcal vaccine**—once; plus one-time revaccination five years later for patients with chronic illness or post-splenectomy patients

Women: Ages 40 and Older	
General Health	
Age	**Service covered**
40-64 years	Preventive care visit every 1-3 years
45-65 years	Blood cholesterol/lipids every 5 years; after age 65, at physician discretion based on risk factors
50+ years	Fecal occult blood home test for colorectal cancer during each preventive care visit
50+ years	Flexible sigmoidoscopy every 48 months
50+ years	Colonoscopy every 10 years, but not within 48 months of sigmoidoscopy
65+ years	Preventive health visit once a year
65+ years	Bone density screening using a combination of validated risk questionnaires and densitometry techniques every 2 years; may begin at age 60 if you are at risk
Breast Health	
Age	**Service covered**
40-69 years	Breast exam with each preventive care visit
50-69 years	Mammogram every 1-2 years depending on risk factors; may begin at age 40 if you are at risk
70+ years	Breast exam with each preventive care visit and mammogram depending on general health and risk factors

For more information on what isn't covered and benefit limits, see "Summary of Benefits" and "Expenses Not Covered, Exclusions, and Limitations."

Preventive Care *(continued)*

Women: Ages 40 and Older	
Gynecological Health	
Age	**Service covered**
40+ years	Pap smears and pelvic exams every 1-3 years
Immunizations	
Age or other indications	**Service covered**
40+ years	**Tetanus/Diptheria (Td) booster** once every 10 years
40+ years	**Varicella** (if no history of chickenpox and not previously immunized)
50+ years (or younger with chronic illness)	**Influenza vaccine**, annually
65+ years (or younger with chronic illness)	**Pneumococcal vaccine**—once; plus one-time revaccination five years later for patients with chronic illness or post-splenectomy patients

For more information on what isn't covered and benefit limits, see "Summary of Benefits" and "Expenses Not Covered, Exclusions, and Limitations."

Radiation and Chemotherapy

This benefit covers therapeutic application of radiation and chemotherapy.

Second Opinions

This benefit covers:

- Second opinions *required* under the UMP's medical review/preauthorization or case management program (failure to obtain a second opinion when required may reduce your benefits by up to $200 or cause denial of benefits).
- Second opinions you *choose* to have, without UMP requirements.

Except in an emergency, a second opinion is almost always a good idea before any major procedure or treatment program. The benefit of a second opinion may be greatest if you:

- Tell your attending physician you would like a second opinion
- Try to get your opinion from a doctor unaffiliated with the first (preferably practicing at another institution)
- Consider seeking a non-surgical opinion for second opinions on surgery
- Let the second opinion provider know that you expect to have a thorough review of records, interview, and physical exam

Skilled Nursing Facility

Preauthorization is required for inpatient skilled nursing facility benefits.

This benefit covers accommodations, services, and supplies to treat an accidental injury, illness, or other covered condition–when provided in and billed by a state-licensed, Medicare-certified skilled nursing facility.

You must require continued services of skilled medical or allied health professionals that cannot be provided on an outpatient basis. Benefits are limited to 150 days per calendar year, unless the UMP approves additional coverage in place of inpatient hospitalization.

Skilled nursing facility confinement for mental health conditions, mental retardation, or for care which is primarily domiciliary, convalescent, or custodial in nature is not covered.

Special Nursing Services

Acute skilled nursing services in the home or hospital by a nurse-level provider, when not received through a hospice or home health care agency, are covered to a maximum of $5,000 per person per calendar year.

Spinal and Extremity Manipulations

Manipulations of the spine or extremities, performed by a chiropractor, osteopathic physician, or other approved provider type, including related office visits and diagnostic tests/x-rays, are covered to a combined total of 10 visits per calendar year. (One or more of these services performed in a single encounter will count as one "visit.")

Any diagnostic test, treatment, or x-ray required to diagnose or treat spinal subluxations or covered extremity disorders will be denied once the 10-visit limit has been reached.

Temporomandibular Joint (TMJ) Treatment

Surgical treatment for TMJ disorders is covered when preauthorized. Medical or dental treatment for TMJ disorders is not covered.

Tobacco Cessation Program

This benefit is not subject to the annual medical/surgical deductible.

The benefit covers services by the *Free and Clear* tobacco cessation program only, which provides phone counseling and education materials to a lifetime maximum of $250 per enrollee. If nicotine replacement therapy, Zyban, or other drugs are advised by *Free and Clear* counselors, the prescription must be obtained from your provider and will be covered under the prescription drug benefit. These authorized prescription

Required second opinions are covered at 100% of the allowed charge and are not subject to the annual medical/surgical deductible.

For more information on what isn't covered and benefit limits, see "Summary of Benefits" and "Expenses Not Covered, Exclusions, and Limitations."

Enrollees diagnosed with certain chronic medical conditions and pregnant women (or women planning to become pregnant) may be able to receive services and drugs prescribed in conjunction with Free and Clear *paid at 100%. For more information on this benefit exception, call the UMP at 1-800-762-6004 or 425-670-3000 in the Seattle area.*

drugs are not subject to the annual prescription drug deductible or the $250 lifetime maximum.

For more details or to enroll in the program call 1-800-292-2336.

Tobacco or smoking cessation programs other than *Free and Clear* are not covered.

Vision Care (Routine)

This benefit is not subject to the annual medical/surgical deductible. It covers routine eye exams, including refractions, once every two calendar years.

An allowance of $100 toward prescription eyeglass lenses, frames, contact lenses, and fitting fees is provided every two calendar years and is not subject to coinsurance.

For more information on what isn't covered and benefit limits, see "Summary of Benefits" and "Expenses Not Covered, Exclusions, and Limitations."

Expenses Not Covered, Exclusions, and Limitations

In addition to any exclusions and maximums/limits mentioned in other sections of this *Certificate of Coverage*, the UMP does not cover:

1. Acupuncture, except as described under "Acupuncture" in "Covered Expenses."
2. Additional portion of a physical exam beyond what is covered by the preventive care benefit (starting on page 43), such as that required for employment, travel, immigration, licensing, or insurance and related reports.
3. Alcohol/drug information or referral services or enrollment in Alcoholics Anonymous or similar programs such as services provided by schools or emergency service patrol.
4. Air ambulance, if ground ambulance would serve the same purpose, or transportation by "cabulance" or other nonemergency service.
5. Any services or supplies not specifically listed as covered.
6. Autologous blood and its derivatives, including extraction or storage except when used for a covered peripheral stem cell rescue procedure.
7. Circumcision, unless determined medically necessary for a medical condition.
8. Complications directly arising from services not covered.
9. Conditions caused by or arising from acts of war.
10. Convalescent or custodial care (intended primarily to assist in activities of daily living and not requiring continued services of skilled medical or allied health professionals).
11. Cosmetic services or supplies except for:
    - Reconstructive breast surgery following a mastectomy necessitated by disease, illness, or injury
    - Reconstructive surgery of a congenital anomaly
    - Restoring function
12. Court-ordered care, unless determined by UMP to be medically necessary and otherwise within the UMP's coverage criteria.
13. Dental care other than the specific covered dental services listed on pages 34-35. For example, the following are not covered:
    - Any treatment of caries or gum disease (including, but not limited to, extractions or aveoloplasties), or other dental-specific services, regardless of the cause
    - Dental implants
    - Malocclusion resulting from accidental injury
    - Nonsurgical treatment of temporomandibular joint (TMJ) dysfunction or myofascial pain dysfunction
    - Orthodontic treatment
    - Orthognathic surgery
    - Treatment of injuries caused by biting or chewing
    - Nitrous oxide
14. Drugs or medicines not prescribed by an approved provider type, or not requiring a prescription, except as listed in exclusion 40.

15. Educational programs, such as nutritional counseling for cholesterol control, or lifestyle modification programs, except as described under "Diabetes Education" on page 35 and "Tobacco Cessation Program" on page 51.
16. Electron Beam Tomography (EBT), self-referred or prescribed by a provider.
17. Equipment such as:
    - Air conditioners or air purifying systems
    - Arch supports
    - Corrective shoes (except for diabetes)
    - Convenience items/options
    - Exercise equipment
    - Sanitary supplies
    - Special or extra-cost features
18. Experimental or investigational services, supplies, or drugs.
19. Food supplements (other than for PKU), such as infant or adult dietary formulas.
20. Foot care routine procedures, treatment of corns and calluses, corrective shoes, treatment of fallen arches or symptomatic complaints of the feet, orthotics, or related prescriptions. (Foot care appliances for prevention or treatment of diabetes complications, however, are covered.)
21. Hearing care services or supplies such as:
    - A hearing aid that exceeds specifications prescribed for correction of hearing loss
    - Charges incurred after plan coverage ends, unless the hearing aid was ordered before that date and is delivered within 45 days after UMP coverage ends
    - Purchase of batteries or other ancillary equipment, except those covered under terms of the initial hearing aid purchase
22. Home health care such as:
    - 24-hour or full-time care in the home, unless preauthorized
    - Any services or supplies not included in the home health care treatment plan or not specifically mentioned under "Covered Expenses" starting on page 33.
    - Dietary assistance
    - Homemaker, chore worker, or housekeeping services
    - Maintenance or custodial care
    - Medically unnecessary services
    - Nonclinical social services
    - Psychiatric care
    - Separate charges for records, reports, or transportation
    - Services by family members or volunteer workers
    - Supportive environmental materials/improvements (handrails, ramps, etc.)
    - Visits exceeding two hours per day, or daily visits beyond 14 consecutive days that have not been preauthorized
23. Hospice care such as:
    - Any services or supplies not included in the hospice care plan, not specifically mentioned under "Hospice Care" on page 37, or provided in excess of the specified limits
    - Expenses for normal necessities of living such as food, clothing, or household supplies, Meals on Wheels, or similar services
    - Homemaker, chore worker, or housekeeping services (except as provided by home health aides as part of the hospice program)
    - Legal or financial counseling
    - Separate charges for records, reports, or transportation

- Services by family members or volunteer workers
- Services provided while the enrollee is receiving home health care benefits
- Services to other than the terminally ill enrollee including bereavement, pastoral, or spiritual counseling
- Supportive environmental materials/improvements (handrails, ramps, etc.)

24. Hospital inpatient charges such as:
    - Admissions solely for diagnostic purposes that could be performed on an outpatient basis
    - Beds "reserved" while the patient is being treated in a special-care unit or is on leave from the hospital
    - Personal items (television, special diets not medically necessary to treat the covered condition, or convenience items)
    - Private room charges, unless medically necessary and approved by the UMP
25. Immunizations, except as described under "Preventive Care" starting on page 43. Immunizations for the purpose of travel or employment are not covered.
26. Impotence treatment with medications or pharmaceuticals.
27. Infertility or sterility testing or treatment, such as artificial insemination or in vitro fertilization.
28. Learning disabilities treatment after diagnosis, including for dyslexia, except as described under "Neurodevelopmental Therapy" on page 39.
29. Maintenance therapy (see definition of maintenance care on page 85).
30. Manipulations of the spine or extremities, except as described under "Spinal and Extremity Manipulations" on page 51.
31. Marital, family, sexual, or other counseling or training services, except services provided by a UMP network licensed marriage and family therapist for neuropsychiatric, mental, or personality disorders.
32. Massage therapy, unless services meet the criteria in "Physical, Occupational, Speech, and Massage Therapy" under "Covered Expenses"; see page 42. Services from massage therapists who are not UMP network providers are not covered.
33. Mental, neuropsychiatric, or personality disorder treatment, except as described under "Mental Health Treatment" on pages 38-39.
34. Missed appointments, or completing or copying forms or records, except copying records to perform retrospective utilization review.
35. Non-network and out-of-network provider charges in excess of the plan's allowed charges.
36. Obesity treatment, including any medical services, drugs, supplies, or surgery such as gastroplasty, gastric stapling, or intestinal bypass.
37. Organ donor coverage for anyone who is not a UMP enrollee, or for locating a donor (such as tissue typing of family members), except as described under "Organ Transplants" on page 41.
38. Organ transplants or related services in nondesignated facilities, or transportation or living expenses related to organ transplants. See "Plan-Designated Facilities" on page 86.

39. Orthoptic therapy (eye training) or vision services, except as described under "Vision Care (Routine)" on page 52.
40. Over-the-counter drugs, except the following products when prescribed by an approved provider type licensed to prescribe drugs: insulin; prenatal vitamins; and nicotine replacement therapy (while participating in the *Free and Clear* tobacco cessation program).
41. Recreation therapy.
42. Replacement of lost or stolen medications.
43. Residential mental health treatment programs or care in a residential treatment facility.
44. Reversal of voluntary sterilization (vasectomy or tubal ligation).
45. Services or supplies to the extent benefits are *available* under any automobile medical, automobile no-fault, workers' compensation, personal injury protection, commercial liability, commercial premises medical, homeowner's policy, or other similar type of insurance or contract, if it covers medical treatment of injuries. (Benefits are considered *available* if you are a named insured, come within the definition of insured, or are a third-party beneficiary under the policy.) However, UMP payments will be advanced upon request if you agree to apply for benefits under the other insurance or contract and to reimburse the UMP when settlement is received.
46. Services delivered by types of providers not listed as approved on pages 26-28, or by providers delivering services of a type or in a manner not within the scope of their licenses.
47. Services of a non-network or out-of-network Licensed Master of Social Work, Licensed Mental Health Counselor, Licensed Marriage and Family Therapist, or non-PhD psychologist, except when employed by and delivering services within a community mental health agency and that agency bills for such services.
48. Services of an out-of-network or non-network massage therapist/practitioner.
49. Services or drugs related to tobacco use and smoking cessation, except as described under "Preventive Care" and "Tobacco Cessation" in "Covered Expenses."
50. Services or supplies:
    - For which no charge is made, or for which a charge would not have been made if you had no health care coverage
    - Provided by a family member
    - That are solely for comfort (except as described in "Hospice Care" in "Covered Expenses" on page 37)
    - For which you are not obligated to pay
51. Services or supplies obtained through a "private contract" agreement with a physician or practitioner who does not provide services through the Medicare program–when Medicare is the primary payer.
52. Services received outside of required case management when you are required to participate in and comply with a case management plan as a condition of continued benefit payment (see page 30 for details and exceptions).
53. Sexual disorder, diagnosis, or treatment.

54. Sexual reassignment surgery, services, counseling, or supplies.
55. Skilled nursing facility services or confinement for:
    - Mental health conditions
    - Mental retardation
    - Primarily domiciliary, convalescent, or custodial care.
56. Surgical treatment to alter the refractive character of the cornea, such as radial keratotomy, photokeratectomy, or LASIK surgery.
57. Vitamins (except prenatal vitamins during pregnancy, when prescribed by an approved provider type licensed to prescribe drugs), minerals, or nutritional supplements.
58. Weight-loss drugs, services, or supplies.
59. Wilderness training programs for chemical dependency.

If you have questions about whether a certain service or supply is covered, call the UMP at 1-800-762-6004 or 425-670-3000 in the Seattle area.

Filing a Claim

For services from out-of-network or non-network providers, submit a completed *Uniform Medical Plan Claim Form* to the UMP at the address on the claim form. For prescription drugs from non-network pharmacies, submit a completed *Retail Prescription Drug Claim Form* to the address on the claim form. Forms are available from the UMP or on the UMP Web site at *www.ump.hca.wa.gov*. Prescription drug claim forms are also available through Medco Health Customer Service or the Medco Health Web site (*www.medcohealth.com*).

When the UMP is your primary payer (as defined on page 86), *network providers and network pharmacies will bill the plan for you.* (So even if you receive a bill from a network provider, since they're responsible for filing, don't submit the claim.)

If you need to submit a claim yourself, the main steps to follow are described below.

Assembling Information

Your itemized bills should include:

- Patient's name
- Description of the illness or injury (usually a code number)
- Date and type of service
- Provider's name, address, and fee

The claim cannot be processed without this information. The *HCFA 1500 Form* is the most common format used by providers to bill for professional services. Cash register receipts, balance due statements, or payment receipts can't be used to determine claim payments.

If you go to a non-network pharmacy, you must complete and sign a *Retail Prescription Drug Claim Form* for reimbursement. Pharmacy receipts alone are not acceptable for claim reimbursement unless they identify the drug name(s), date of purchase, dosage, and quantity of the drug as well as the pharmacy name and patient's name.

Submitting Your Claim

All claims for services from out-of-network or non-network providers, or non-network pharmacies, require submission of a completed *Uniform Medical Plan Claim Form* or *Retail Prescription Drug Claim Form*. Claims for insulin, disposable diabetic supplies, prenatal vitamins, and nicotine replacement therapy preauthorized by your *Free and Clear* counselor must be accompanied by a copy of the prescription from an approved provider type.

Incomplete forms for medical/surgical services will be returned to you, which will delay the processing of your claim. If Medicare or another health plan is the primary payer on the claim, UMP may need to request the Explanation of Benefits statement issued by the other payer before we can finalize payment on the claim. Submit a separate claim for each person, although multiple medical services or retail prescriptions for the same person may be included on a single form. Do not use nicknames or initials on claim forms or bills. Keep a copy of all documents for your records, and send your medical/surgical claim (or any correspondence about your claim) to:

Uniform Medical Plan
P.O. Box 34850
Seattle, WA 98124-1850

Retail Prescription Drug Claim Forms should be sent to:

Medco Health
P.O. Box 2277
Lee's Summit, MO 64063-2277

The plan will not pay claims filed more than 12 months after the date of service.

See "Services Received Outside the U.S." on page 28 for additional instructions.

Explanation of Benefits (EOB)

An EOB is the detailed account of each claim processed by a medical plan, which is sent to you to describe claim payment or denial.

EOBs for medical/surgical services display each UMP claim submitted.

EOBs for retail prescription drugs purchased at a participating pharmacy will not be sent unless requested. If an EOB is necessary to coordinate benefits for retail drugs with other coverage, please call Medco Health Customer Service at 1-800-903-8224 or visit the Medco Health Web site at *www.medcohealth.com* where you (and only you) can access your private account.

For information on coordinating benefits with another health plan, see "If You Have Other Medical Coverage" on pages 67-68.

What Happens Next

Benefits are calculated according to UMP provisions. As described above, you will receive an EOB showing how each of your medical/surgical claims was processed. Be sure to keep the original EOB, since it's your only record of claim payment. You may need it for tax purposes or if there are any questions about payment to the provider.

Who Gets the Money When Claims Are Paid

If you use a network provider, the UMP will send payments directly to the provider when the claim is processed. Therefore, you shouldn't pay a network provider for medical/surgical services until the UMP has paid its part of the bill (unless you haven't met your annual medical/surgical deductible).

If you use an out-of-network or non-network provider (other than a hospital), payment may be sent to you or to the provider, depending on your answer to "Have you paid for these charges?" on the claim form, the amount of reimbursement, and whether you assign payment to the provider. Claim payments for hospitals are almost always sent directly to the hospital, regardless of its status as a network, out-of-network, or non-network provider.

When payment goes to the provider, you and the provider receive an EOB detailing what services were covered and how benefits were calculated. Your EOB will have a check attached if payment is due to you.

If you submit claims for retail prescription drug purchases from non-network pharmacies, you will receive reimbursement by mail directly from Medco Health following the processing of your claim.

If you have questions about filing a claim or the status of a claim, contact UMP Customer Service at 1-800-762-6004 or 425-670-3000 in the Seattle area.

Calculating Benefits When UMP is Your Primary Coverage: Some Sample Claims

The following examples illustrate how benefits are calculated when UMP is the primary payer. Assume any annual deductible has been met, and any applicable out-of-pocket limit has not been reached.

Network provider in WA, OR, and four Idaho counties (Bonner, Kootenai, Latah, and Nez Perce):			
Billed Charge	**UMP Allowed Charge**	**UMP Pays**	**You Owe**
$1,000	$900	$810 (90% x $900)	$90 ($900-$810)

Network provider* (Beech Street) outside WA, OR, and four Idaho counties (Bonner, Kootenai, Latah, and Nez Perce):			
Billed Charge	**UMP Allowed Charge**	**UMP Pays**	**You Owe**
$1,000	$900	$720 (80% X $900)	$180 ($900-$720)

Non-network provider:			
Billed Charge	**UMP Allowed Charge**	**UMP Pays**	**You Owe**
$1,000	$900	$540 (60% x $900)	$460 ($1,000-$540)

Out-of-network provider (no access to network providers, including out of country)			
Billed Charge	**UMP Allowed Charge**	**UMP Pays**	**You Owe**
$1,000	$900	$720 (80% x $900)	$280 ($1,000-$720)

*Not applicable when Medicare is the primary coverage.

Complaint and Appeal Procedures

Medical/Surgical

Complaints

If you want to register a complaint, call 1-800-762-6004 or 425-670-3000 in the Seattle area from 8 a.m. to 6 p.m. weekdays, or write UMP Customer Service at:

Uniform Medical Plan
Correspondence
P.O. Box 34578
Seattle, WA 98124-1578

Complaints regarding quality of care, providers, and availability of health care will be referred to the Medical Review Department for consideration. Complaints related to nonmedical problems will be referred to the Customer Service or Claim manager depending on the specific concern. Most complaints can be resolved at this level.

If you submit a written complaint, UMP will send written confirmation of receipt within five business days. You will also receive written notice of the action on your complaint as soon as possible, or within 30 calendar days of receiving your complaint. The UMP will notify you if additional time is needed for a response.

First-, Second-, and Third-Level Medical/Surgical Appeals

Before you may request an independent review (third-level appeal) as described at the end of this section, you must first exhaust the UMP's two-level appeal process. However, if at any point during the appeal process related to an adverse determination the UMP exceeds the timelines for response without good cause or without reaching a decision, you have the right to an independent review.

If you are appealing a decision to change, reduce, or terminate coverage for services already being provided, the UMP is required to continue coverage for these services during your appeal. However, if the decision to change, reduce, or terminate coverage is upheld, you will be responsible for any payments made by the UMP during that period. If you are appealing to request payment for denied claims or approval of services not yet initiated, the UMP is not required to cover these services while the appeal is under consideration.

First-Level Appeals

First-level appeals may be initiated orally or in writing no more than 120 calendar days after you receive notice of the action leading to the complaint (12 months for claim disputes). Although appeals may be made by phone or in person, putting them in writing with all of the necessary information will expedite the process. Send first-level appeals to:

Uniform Medical Plan
Medical Review
First-Level Appeal
P.O. Box 34578
Seattle, WA 98124-1578

The UMP will notify you within five business days of receiving your appeal.

Your appeal will be reviewed by someone who was not involved in the original adverse determination or complaint. Claim processing disputes will be reviewed by an experienced claim examiner who did not process the original claim. Appeals about covering, authorizing, or providing of health care will be evaluated by a medical review nurse not involved in the initial determination to deny, reduce, modify, or terminate services or benefits. If the medical review nurse's recommendation

What is a complaint?

A complaint is an oral or written expression of dissatisfaction submitted by or for an enrollee regarding:

- *Denial of coverage for health care services or prescription drugs or payment for health care services or prescription drugs*
- *Issues other than denial of coverage or payment, including dissatisfaction, delays, or conflicts with UMP or providers*
- *Dissatisfaction with UMP practices or actions unrelated to health care services or prescription drugs*

What is an appeal?

An appeal is an oral or written request, submitted by an enrollee or his or her representative, or by a provider acting on behalf of an enrollee, to reconsider:

- *UMP's adverse decision regarding a complaint*
- *A claim processing issue*
- *UMP's decision to deny, modify, reduce, or terminate payment, coverage, or authorization/review for health care services or prescription drugs*
- *Eligibility for enrollment in UMP coverage**

**If you have an appeal related to eligibility, call the Health Care Authority at 1-800-700-1555 or write to:*

HCA Appeals Manager
P.O. Box 42684
Olympia, WA 98504-2684

An Independent Review Organization (IRO) is a group of medical and benefit experts certified by the Washington State Department of Health and not affiliated with the UMP in any way. An IRO is intended to provide unbiased, independent, clinical and benefit expertise as well as evidence-based decision making while ensuring confidentiality. UMP will pay the IRO's charges.

is to uphold denial of coverage or a decision is made not to authorize services, the appeal will be further reviewed and decided by the UMP associate medical director.

The first-level appeal decision will usually be made within 30 calendar days of receiving the appeal. If more time is necessary because further information is needed (medical records or a second opinion), we will request your signed consent for an extension beyond 30 calendar days. If we do not receive your signed consent by day 30, the decision will be based on the information at hand.

Second-Level Appeals

Second-level appeals must be submitted within 60 calendar days of response by UMP regarding the first-level appeal. Send second-level appeals to:

Uniform Medical Plan
Appeals Committee
Second-Level Appeal
P.O. Box 34578
Seattle, WA 98124-1578

The second-level review will be performed by the UMP Appeals Committee, consisting of the UMP executive director or designee, UMP medical director, and deputy program manager of Compliance and Enforcement. If indicated, additional input will be sought from health care providers not involved in the first-level appeal who have appropriate expertise in the field of medicine related to your condition or disease.

The same turnaround times that apply to first-level appeals also apply to second-level appeals. At your request, you and your authorized representative may meet with the UMP Appeals Committee in the Seattle, Washington, office either in person or by teleconference during this level of appeal, to discuss the reasons you disagree with the first-level appeal decision.

Third-Level Appeals (Independent Review)

For medical/surgical appeals, you may request an independent review within 180 days of UMP's decision if:

- You are dissatisfied with the second-level appeal outcome and your appeal is related to a denial, change, or termination of payment, coverage, or authorization of care; or
- UMP does not meet timelines for response on a first- or second-level appeal.

To request an independent review, write to:

Uniform Medical Plan
Independent Review Process
P.O. Box 91118
Seattle WA 98111-9218

Any litigation against the UMP must be brought in the Superior Court of Thurston County.

Appeals That Must Be Handled in Less Than 30 Days

- Medical emergency requests that could seriously jeopardize your life, health, or ability to regain maximum function, as determined by your attending physician or the UMP medical director, will be decided within 72 hours of the date the appeal is received.
- Denial of an experimental or investigational service will be made within 20 calendar days from the date we receive your appeal of a fully documented claim; an extension of this deadline will require your written consent.

Prescription Drugs

Complaints

If you are dissatisfied with a denial of coverage for prescription drugs or payment for them, or with other issues related to your prescription drug benefit such as delays, customer service, or pharmacies, call Medco Health at 1-800-903-8224.

Expedited Appeals for Prescription Drugs

If your coverage is denied by the Home Delivery (mail-order) service or your retail pharmacy, and your provider determines a delay in coverage would seriously jeopardize your life, health, or ability to gain maximum function, ask your provider to request an expedited appeal. The provider should contact the UMP at:

Uniform Medical Plan
Appeals Committee
P.O. Box 91118
Seattle, WA 98111-9218

Phone: 206-521-2000
Fax: 206-521-2001

All clinically relevant information should be submitted. A decision will be issued as quickly as possible but no more than 72 hours after the appeal is received.

Other Prescription Drug Appeals

For certain drugs, the UMP limits quantity or therapeutic uses for which a drug can be covered over a specific period. Your provider may request coverage for these medications in excess of UMP limits if medically necessary. If you are adversely affected by a limit on a prescription drug that is subject to coverage review (see pages 30-32), then you, your pharmacist, or your prescribing provider may call Medco Health at 1-800-753-2851 to initiate drug coverage review for that particular medication. (If your provider does not call, Medco Health will need to contact your provider before making a decision.) In some instances you may be eligible for a temporary supply while the coverage review is in process. If you choose to receive the drug outside UMP's conditions, you will be responsible for the full cost of any medications for which coverage is denied.

No benefits will be provided for any drug when the FDA has determined its use to be contraindicated.

You have the right to appeal if you or your provider disagrees with how your prescription drug claim was processed.

First-Level Appeals

Clinical appeals: To appeal a coverage denial letter from Medco Health, you or your provider can appeal orally or in writing within 120 calendar days of the denial. In many cases, however, your provider will need to supply clinically pertinent information to Medco Health, so it will expedite the process if your provider initiates the appeal. A decision regarding your appeal will be sent to you (and, if you request, to your prescribing provider) in writing within 30 calendar days of an oral request or 15 calendar days of receipt of your written request for an appeal.

Clinical appeals may be filed by mail, fax, or phone:

Medco Health
5151 Blazer Parkway, Suite B
Dublin, Ohio 43107
Attn: Department of Appeals

Fax: 1-800-711-5673
Phone: 1-800-753-2851

Nonclinical appeals: If you receive a claims denial or reduction, believe the claim was not processed accurately, or have problems with a pharmacist that cannot be resolved at the complaint level, you may initiate an appeal within 120 days from the date the action occurred. To do this, call Medco Health at 1-800-903-8224 or mail your appeal to the following address. You will receive a decision within 30 calendar days from the day your appeal is initiated.

Nonclinical appeals may be mailed to:

Medco Health
P.O. Box 721
Parsippany, NJ 07054
Attn: Department of Appeals

Second-Level Appeals

Second-level appeals must be submitted within 60 calendar days of response by Medco Health regarding the first-level appeal. Send second-level appeals to:

Uniform Medical Plan
Prescription Drug Appeal
Attn: Appeals Committee
P.O. Box 91118
Seattle, WA 98111-9218

Include all information necessary to consider the appeal, including details that may not have been available for the first-level appeal. The UMP will notify you within five business days of receiving your appeal. A written decision will be provided within 30 calendar days of UMP receiving the appeal unless circumstances beyond our control extend the decision-making process. An extension of this deadline will require your written consent. If we do not receive your signed consent by day 30, the decision will be based on the information at hand.

Third-Level Appeals (Independent Review)

You may request an independent review of your prescription drug appeal within 180 days of the plan's decision if:

- You are dissatisfied with the second-level appeal outcome and your appeal is related to a denial, change or termination of payment, coverage, or authorization of care; or
- Medco Health or UMP do not meet timelines for response on a first- or second-level appeal without good cause.

To request an independent review, write to:

Uniform Medical Plan
Independent Review Process
P.O. Box 91118
Seattle, WA 98111-9218

Any litigation against the UMP must be brought in the Superior Court of Thurston County.

If You Have Other Medical Coverage

The UMP coordinates benefits with Medicare and any other group plan that covers you so that, after your deductible(s) have been met, your UMP and other coverage combined will pay up to 100% of allowed charges (but not more than 100%). Benefits are not coordinated with any individual health coverage you have purchased, and this coordination provision does not apply to Medco Health's Home Delivery (mail-order) pharmacy services.

If you are covered by more than one health insurance plan, please submit claims to UMP and the other plan(s) at the same time. This helps to coordinate benefits more quickly.

The group insurance plan that is *primary* will process the claim first for all expenses allowed under its coverage. The primary plan will pay its normal plan benefit. The other plan or plans that cover you will be considered "secondary" and may pay less than their normal plan benefit, since total payments combined cannot exceed 100% of the allowed charges. When Medicare or another government program is one of the payers, federal law determines which plan provides benefits first. If you enroll in Medicare and are still an active employee, your Medicare coverage is secondary to UMP; Medicare becomes primary when you retire. For coordination with plans other than Medicare, the following rules determine which plan is the primary payer:

- When both plans coordinate benefits, the plan covering the person as a subscriber pays first.
- Dependent children are covered first under the plan of the parent whose birthday is earlier in the calendar year. If the parents are separated or divorced, the following rules determine which plan pays first, in this order:
  - Plan of the parent with custody
  - Plan of the spouse of the parent with custody
  - Plan of the parent without custody
  - Plan of the spouse of the parent without custody

  However, if a court decree establishes responsibility for the child's health care, the plan of the parent with that responsibility pays first.
- If the rules above do not determine which plan is primary:
  - The plan that has covered the enrollee for the longer period pays first
  - All other plans provide benefits first if the person is a retiree, a laid-off employee, or a dependent of a person who is retired or laid off if the other plans follow this rule

When none of the rules above determines the order of benefits, the plan that has covered the subscriber for the longer period pays first.

If UMP is the primary payer, the UMP payment will be your normal UMP benefit.

When the UMP Is the Secondary Payer

When the UMP is secondary to another group health plan or Medicare, standard coordination of benefits apply. For Home Delivery prescriptions (mail-order), there is no coordination of benefits. This means that UMP is primary and pays first for all covered prescriptions

purchased through Home Delivery, even if you have other coverage that is normally primary.

For other services, here's how it works when the UMP is not the primary payer:

- The primary payer pays a portion of the bill and sends you an Explanation of Benefits (EOB); you send a copy of the bill and the EOB to UMP
- UMP reviews the primary plan benefit calculation, and the primary plan payment
- UMP determines what the normal benefit would have been if UMP had been the only payer
- UMP compares allowed charges and determines which is the highest allowed charge
- UMP pays the difference between the highest allowed charge and the primary plan's payment, up to the normal UMP benefit amount

Here's an example to illustrate the process and terms above. This example assumes that the primary plan ordinarily pays 80% of allowed charges after a $500 deductible.

Provider charge:	**$1,200**	
Primary Plan Benefit Calculation		
Primary plan's allowed charge:	$1,000	
Primary plan deductible:	$500	
Primary plan pays:	$400	(80% of $500 balance)
UMP Benefit Calculation		
UMP allowed charge:	$900	
UMP deductible:	$200	
UMP normal benefit:	$630	(90% of $700 balance)
Actual Payment by UMP		
Highest allowed charge:	$1,000	(primary plan)
Primary plan's payment:	$400	
UMP payment due:	***$600***	

You owe nothing unless this is a provider who has not agreed to accept the highest allowed charge as payment in full. If a provider is not contracted with the UMP or the primary plan as a network provider, you could be billed for the difference between the provider's actual billed charge and the highest of the plans' allowed charges.

Please contact UMP Customer Service at 1-800-762-6004 or 425-670-3000 in the Seattle area for assistance in answering any questions about benefits when you are covered by more than one plan.

When a Third Party Is Responsible for Injury or Illness

UMP benefits are available if you're injured or become ill because of a third party's action or omission, or if you have a work-related injury not covered by workers' compensation. The UMP will be *subrogated* to your rights against any third party (including workers' compensation) liable for the illness or injury, which means the UMP:

- Is entitled to reimbursement from any amount you recover from the liable third party, if you are fully compensated
- Has the right to pursue claims for damages from the liable third party

The UMP's subrogation rights extend to the full amount of all benefits the plan paid for the illness or injury. As a condition of receiving benefits for the illness or injury, you and your representatives will cooperate fully with the UMP in recovering paid amounts, including but not limited to:

- Providing facts to the UMP about the illness or injury as well as the identity and address of the liable third party, their liability insurers, and their attorneys
- Giving reasonable advance notice to the UMP of any related trial, hearing, or intended settlement
- Repaying the UMP from the proceeds of any recovery

More details on these responsibilities follow. (HCA/UMP rights in this section are in addition to any other remedies available under this *Certificate of Coverage* or otherwise provided by law.)

Your Obligation to Notify the UMP

You must notify the UMP in writing of any claim or lawsuit for an illness or injury for which the plan paid benefits, including:

- The facts of your illness or injury
- Any changes in your illness or injury
- The name of any person responsible for the illness or injury and their insurer
- Advance notice of any settlement you intend to make.

Right of Recovery

If you bring a claim or lawsuit against another person, you also must seek recovery of any benefits paid under the UMP; the plan reserves the right to join as a party. The UMP may, however, recover benefits directly from you or the other person. If so, you don't need to take any action on behalf of the UMP, but you must do nothing to impede the plan's right of recovery.

You are obligated to reimburse the UMP only the excess remaining after you are fully compensated for your loss.

Right to Receive and Release Information

You may be required to give the UMP or the HCA information necessary to determine eligibility, administer benefits, or process claims. This could include medical and other records. Coverage could be denied if you don't provide the information when requested.

False Claims or Statements

Neither you nor your provider (or any person acting for you or your provider) may submit a claim for services or supplies that were not in fact received, or for which you are not expected to pay.

In addition, neither you nor any person acting for you may make any false or incomplete statements on any enrollment application under the UMP.

The HCA may recover any payments made as a result of a false claim, false statement, or overpayment by the UMP by withholding future claim payments or by other means.

Eligibility and Enrollment

Eligible Employees

Employees (referred to in this book as "employees," "subscribers," or, in some cases, "enrollees") of state government, higher education, K-12 school districts, educational service districts, political subdivisions, and employee organizations representing state civil service workers are eligible to apply for coverage by Public Employees Benefits Board (PEBB) plans in accordance with WAC 182-12-115. An employee is eligible for coverage by only one PEBB-sponsored medical plan even if eligibility criteria are met under two or more PEBB employers. A person enrolled in PEBB coverage as a subscriber cannot also be covered as a dependent on the PEBB plan of a spouse or other person.

Eligibility for employees of participating "employer groups" may follow PEBB rules or rules determined by collective bargaining agreement, if approved by the Health Care Authority (HCA) in accordance with WAC 182-12-115.

Eligible Dependents

Eligible subscribers may enroll dependents in their PEBB-sponsored medical plan if the dependent meets the criteria below. A dependent is eligible for coverage by only one PEBB-sponsored medical plan even if eligibility criteria are met under two or more plans. For example, a dependent child that is eligible for coverage under two or more parents or stepparents who are employed by PEBB-participating employers, may be enrolled as a dependent under the coverage of one parent or stepparent, but not more than one. If you're enrolled in a PEBB plan, eligible dependents include your:

- Lawful spouse or same-sex domestic partner (qualified through the *Declaration of Marriage/Same-Sex Domestic Partnership*).
- Dependent children through age 19 including your:
  - Natural children.
  - Stepchildren.
  - Legally adopted children.
  - Children for whom you've assumed legal obligation for total or partial support in anticipation of adoption.
  - Children of your qualified same-sex domestic partner.
  - Children specified in a court order or divorce decree.
  - Married children who qualify as dependents under the Internal Revenue Code.
  - Additional legal dependents approved by the HCA.

Dependent children beyond age 19 are eligible under the following conditions:

- Students age 20-23 are eligible if they depend on you for maintenance/support and are registered and attend full-time an accredited secondary school, college, university, vocational school, or school of nursing. In order to certify and recertify eligibility the subscriber must submit a Student Certification Form to PEBB for review. Along with the certification, the subscriber must provide proof that the dependent (ages 20 through 23) is a full-time student. Acceptable proof may include: i) current quarter/semester registration from institution; or ii) past year report card/transcript from institution showing credit hours completed. If documentation identifies a non-eligible period for the dependent, coverage will be terminated for that time period the student was not eligible. Payment for any services provided to the ineligible student will be your responsibility. Dependent student coverage continues year-round for those who attend three of the four school quarters, and for three full calendar months after graduation, as long as you are covered at the same time.

- Dependent children of any age are eligible if incapable of self-support due to developmental disability or physical handicap, if their condition occurred before age 20 or while covered under a PEBB plan as a full-time student. In order for coverage to continue beyond the limiting age or loss of student eligibility, an application and proof of disability must be submitted to the HCA. The HCA will request recertification of disability as frequently as necessary to verify the ongoing eligibility status of the dependent during the first two year period following the child's attainment of the limiting age, and may request proof of disability annually thereafter.

Dependent parents covered under a PEBB plan before July 1, 1990 may continue enrollment on a self-pay basis if:

- They maintain continuous coverage in a PEBB plan and continue to qualify under the Internal Revenue Code as your dependent;
- You continue enrollment in a PEBB plan; and
- Your parents are not covered by any other group medical insurance.

Dependent parents may be enrolled in a different PEBB plan than you; however, they may not add additional family members to their coverage.

Dependents previously covered under a K-12 medical plan who aren't otherwise eligible for PEBB coverage may continue under a PEBB plan for up to 36 consecutive months. To be eligible for this continuation, the PEBB plan must be immediately replacing a K-12 medical plan with no lapse in coverage.

Dependents who lose eligibility under a PEBB plan due to your death may continue under a retiree plan if they will immediately begin receiving a monthly benefit from any Washington State-sponsored retirement system. Your spouse or qualified same-sex domestic partner may continue coverage indefinitely; other dependents may continue coverage until they lose eligibility under PEBB rules.

Surviving dependents must make application to enroll in PEBB coverage or waive the coverage, while enrolled in other comprehensive employer-provided coverage within 60 days of your death. For dependents who will not receive the monthly retirement benefit, see "Options for Continuing Benefits" starting on page 77.

Enrolling in the Plan

You and your eligible dependents may enroll in the UMP within 31 days of the date you first become eligible to apply for coverage, as shown in the chart on page 73. Enrollment forms are available from and must be returned to your payroll, personnel, or insurance office within 31 days of the date of eligibility.

If you don't enroll dependents when they're first eligible, you may enroll them if they lose coverage under another medical plan. They must be enrolled within 31 days of when that coverage ends. These dependents are required to provide proof of continuous coverage to the HCA to establish eligibility.

Eligible employees and dependents may be added to coverage during any open enrollment period determined by the HCA or, in most cases, if the employee acquires a new dependent as a result of marriage, qualified same-sex domestic partnership, birth, adoption or placement for adoption. Eligible employees and dependents may be added in these situations without proof of continuous coverage.

An employee/dependent is eligible to enroll in only one PEBB-sponsored medical plan even if eligibility criteria are met under two or more plans.

Verification of the dependency status of anyone enrolled under PEBB coverage may be requested at any time by the HCA or UMP.

Waiving Coverage

You may waive medical coverage for yourself and your dependents if covered by another medical plan. To do this, you must complete an enrollment form identifying the individuals waiving coverage. If you waive coverage for yourself, coverage is automatically waived for all your dependents, but you may enroll only yourself and waive coverage for any or all dependents. If you waive medical coverage for yourself and your dependents, you will remain enrolled in the PEBB dental plan. You also remain enrolled in life and long-term disability coverage.

After waiving medical coverage, you or your dependents may not enroll in a PEBB plan until the next open enrollment period, or within 31 days of losing other medical coverage. Proof of other medical coverage is required to demonstrate coverage was continuous from the date this coverage was waived, and that the period between loss of coverage and application for this coverage was 31 days or less.

You or your dependents may also enroll before the next open enrollment period if you gain a new dependent through marriage, establishment of a qualified same-sex domestic partnership, birth, adoption, or placement for adoption. Your personnel, payroll, or insurance office must receive your enrollment form within 31 days of the marriage or establishment of a qualified same-sex domestic partnership or within 60 days of the birth, adoption, or placement for adoption.

When Coverage Begins

Employees

The chart below shows when your UMP coverage starts:

If you're a…	You're eligible to apply for coverage on…
Permanent, seasonal, or career seasonal	First day of the month after your date of employment (if your date of employment *is* the first working day of the month, your coverage begins that day)
Nonpermanent employees	First day of the seventh month after your date of employment
Part-time faculty employees	First day of the month after your second consecutive quarter/semester begins (if the first day of your second consecutive quarter/semester *is* the first working day of the month, your coverage begins that day)
Legislator	First day of the month after your term begins (if your term begins *on* the first working day of the month, your coverage begins that day)
Legislative/executive branch appointed or elected official or a judge	First day of the month after your term begins or after you take oath, whichever is earlier (if your term begins or you take oath *on* the first working day of the month, your coverage begins that day)
Participating school district or political subdivision employees	Day allowed under PEBB rules or HCA-approved collective bargaining agreement

Dependents

Coverage for your eligible dependents begins the day your coverage begins if you list the dependents on your enrollment form.

For newly acquired dependents (except newborn or adoptive children) who are enrolled in accordance with PEBB rules, coverage begins the first day of the month after the marriage or qualified same-sex domestic partnership declaration. If the marriage or declaration is on the first of the month, coverage begins that day. You must enroll your spouse or qualified same-sex domestic partner within 31 days of the marriage or declaration.

For new dependent children, coverage for a newborn begins at birth. Coverage for a new adopted child begins the date you assume legal obligation for total or partial support in anticipation of adoption. You must enroll new dependent children within 60 days of the birth or adoption if the addition of the child increases your monthly premium.

Coverage for other new dependents begins the first of the month after the date their dependent status is established and approved by the HCA. If dependent status is established and approved the first day of a month, coverage begins that day.

Special Enrollment for Employees and Their Dependents Who Previously Waived Coverage

If you waived medical coverage for yourself and/or dependents because of other medical coverage, then lose that coverage, UMP coverage begins the first day of the month after the other coverage ends. You must enroll within 31 days of the other coverage ending, and proof of other continuous coverage is required. You must enroll in order to enroll your dependents.

1. Coverage for you and your dependents enrolling because of loss of other medical coverage will begin on the first day of the month following the date the prior coverage terminated. The application must be received by your payroll, personnel, or insurance office within 31 days of termination of other medical coverage, and proof of other continuous coverage must be provided.
2. Coverage for you and your new dependents enrolling following a marriage or establishment of a qualified same-sex domestic partnership will begin on the first day of the month following the date of marriage or the date that the same-sex domestic partnership qualifies based on the declaration. If the date of marriage or establishment of a same-sex domestic partnership is the first calendar day of the month, coverage will begin on the date of marriage or establishment of a qualified same-sex domestic partnership. The application for coverage must be received by your payroll, personnel, or insurance office within 31 days of the date of marriage or date that the same-sex domestic partnership qualifies based on the declaration.
3. Coverage for you and your dependents enrolling following a birth or placement of a child for adoption will begin on the first day of the month in which the birth or placement occurred. Coverage for a newborn child will begin at birth. Coverage for a child placed for adoption will begin on the date that you assume a legal obligation for total or partial support in anticipation of adoption of the child. The application for coverage must be received by your payroll, personnel, or insurance office within 60 days of the birth or date of placement.

If Your Situation Changes After Enrolling

If You Become Eligible for Medicare

If you become eligible for Medicare, contact the nearest social security office to inquire about the advantages of immediate or deferred Medicare enrollment. Please contact the HCA for information about retiree eligibility and benefits.

If you or your spouse or qualified same-sex domestic partner are age 65 or older and you remain an eligible employee, the PEBB plan is the primary payer (see "Definitions" on page 86) and Medicare coverage is secondary; however, you're entitled to accept or reject coverage under the PEBB plan. If you reject this plan, Medicare becomes the primary payer for Medicare-covered health services. Employers cannot provide a plan that pays supplemental benefits for Medicare-covered services nor subsidize such coverage. An employer may, however, offer a plan that pays for health care services not covered by Medicare, such as hearing aids, routine dental care, and physical check-ups. Before selecting Medicare as primary coverage, please contact the HCA for more details.

Medicare regulations allow deferral of enrollment in Medicare Part B in most situations for you and your spouse; this deferral is allowed without penalty up to the date you terminate employment or retire. At retirement, you must enroll in both Parts A and B of Medicare to remain eligible for PEBB coverage. Medicare will become the primary payer in most cases, and this plan becomes secondary. If you retire on or after July 1, 1991, you and your spouse or qualified same-sex domestic partner and dependents must be enrolled in Medicare Parts A and B if eligible.

If You Want to Add a Dependent Acquired After Your Effective Date of Coverage

You may enroll dependents who become eligible after your effective date of coverage. A newly eligible dependent must be enrolled within 31 days of eligibility, except that:

1. For a newborn or a child adopted or placed for adoption, your personnel, payroll, or insurance office must receive your enrollment form within 60 days of the birth, adoption, or placement if addition of the child increases the premium. When additional premium is not required, you should notify your personnel, payroll, or insurance office of the birth or the placement of the adopted child as soon as possible in order to ensure timely payment of claims. When a newborn or adopted child becomes eligible before the 16th day of the month and the addition of the child increases the premium, the new full month's premium is charged; otherwise, the new premium will begin with the next full calendar month.
2. For dependents who lose other medical coverage, your personnel, payroll, or insurance office must receive your enrollment form within 31 days of the date their other coverage ends. These dependents will be required to provide proof of continuous medical coverage. If the dependent meets enrollment criteria and premiums are paid, coverage will begin the first day of the month following the date other coverage is terminated.
3. You may add eligible dependents during any HCA open enrollment period without proof of continuous coverage.

Contact your personnel, payroll, or insurance office or the HCA for an enrollment form.

If You Want to Discontinue Coverage for a Dependent

You may delete a dependent from coverage by submitting a *2003 Medical and Dental Coverage* form to your personnel, payroll, or insurance office. It's important to keep these records current–otherwise your dependent could lose COBRA continuation privileges and have claims denied retroactively. (See "Options for Continuing Benefits" on page 77 for more information.) Please be sure to make enrollment changes as soon as possible.

If You Want to Change Plans Mid-Year

Other than during any HCA open enrollment period, you may change medical plans in the following situations:

- Within 31 days of moving, under these conditions:
  - If you move from your plan's service area, you may enroll in any plan available in your new location; or, if a plan hasn't been available and you move into a plan's service area, you may enroll in that plan.
  - These plan enrollment changes take effect on the first day of the month after the date you move.
- If a court order requires you to provide medical coverage for an eligible spouse or child, you may change medical plans and add the dependent immediately. The change is retroactive to the effective date of the court order or to the date your coverage began, whichever is later.
- If you retire, you may change plans when you apply for retiree coverage. The change becomes effective on the first day of the month after your retirement date.
- Seasonal employees whose off-season occurs during open enrollment may change plans within 31 days of returning to work.

To change plans, you must submit a *2003 Medical and Dental Coverage* form to your personnel, payroll, or insurance office.

If your doctor or health care facility discontinues participation in the UMP, you may not change plans until the next open enrollment period. If your benefits are continued on a self-pay basis or when you return to active status from self-pay, you must remain in the same plan unless you meet one of the criteria stated above. Also, if you transfer between agencies or schools, you're permitted to change plans only within the situations listed above.

When Coverage Ends

Coverage ends on the earliest of these dates:

- For any enrollee, coverage ends the date the plan terminates, if that occurs. Persons losing coverage will have the opportunity to enroll in another PEBB plan.
- For an employee who declines or is ineligible to continue self-pay coverage, coverage ends:
  - At midnight on the last day of the month the employee is in pay status, or
  - At the end of the last month for which the employer paid a premium contribution for reasons other than the employee's termination (such as leave without pay, reduction in force, retirement, or application for disability retirement).
- For a dependent who declines or is ineligible to continue self-pay coverage, coverage ends at the end of the month dependent status stops (such as a non-student child reaching age 20, or a spouse when a divorce decree is final).

- For an enrollee continuing self-pay coverage, coverage ends:
  - On the date of enrollment in other group medical coverage
  - At the end of the last month of eligibility to continue coverage or for which the premium has been paid.
- For a terminated employee continuing self-pay coverage, the employer/employee-paid premium will cover the employee through the end of the month termination of employment occurs, and the self-pay premium will cover the employee beginning the first of the next month.

Premium payments are not prorated if you die or terminate coverage prior to the end of the month. No refund will be made.

If an enrollee or newborn eligible for benefits under "Obstetric and Newborn Care" is confined in a hospital or skilled nursing facility for which benefits are provided when PEBB coverage ends and the enrollee is not immediately covered by other health care coverage, benefits will be extended until:

- The enrollee is discharged from the hospital or from a hospital to which the enrollee is directly transferred;
- The enrollee is discharged from a skilled nursing facility when directly transferred from a hospital when the skilled nursing facility confinement is in lieu of hospitalization;
- The enrollee is discharged from the skilled nursing facility or from a skilled nursing facility to which the enrollee is directly transferred;
- The enrollee is covered by another health plan which will provide benefits for the services; or
- Benefits are exhausted, whichever occurs first.

When coverage ends, the enrollee may be eligible for continuation of coverage or conversion to other health care coverage if application is made within 31 days after coverage would normally end.

Options for Continuing Benefits

You and your covered dependents have options for continuing coverage during loss of eligibility, as follows. If you have questions about any of these options for continuing benefits, call the HCA at 1-800-700-1555.

Returning After a Leave

If you elect to self-pay during an approved leave without pay, you're eligible for benefits the first of the month you return to work in an eligible position. Your self-pay premium will be refunded and your employing agency will be responsible for collecting your premium and remitting both the employer and employee contributions to the HCA for that month.

If you elect *not* to self-pay during an approved leave without pay, you're eligible for benefits the first of the month *after* you return to work in an eligible position.

Family and Medical Leave Act of 1993 (FMLA)

Employer contributions toward your PEBB plan coverage will continue up to the first 12 weeks of approved family leave, under the FMLA. You must also continue to pay your premium contribution during this period to maintain eligibility. After that, you may continue coverage under PEBB rules as explained below under "Continuing Coverage Under PEBB Rules."

Career Seasonal Employees

Career seasonal/instructional employees are eligible for employer contributions during the off season following each period of seasonal enrollment. Seasonal employees are not eligible for employer contributions during the breaks between seasons of employment, but may be eligible to continue self-pay coverage.

Payment of Premium During a Labor Dispute

Any employee or dependent whose monthly fees hereunder are paid in full or in part by the employer, may pay the fees directly to the HCA if the employee's compensation is suspended or terminated directly or indirectly as a result of a strike, lockout, or any other labor dispute for a period not to exceed six (6) months.

During the period the employee's compensation is suspended or terminated, the employee shall be notified immediately by the HCA, in writing, by mail addressed to the last address of record with the HCA, that the employee may pay the fees as they become due as provided in this section.

Continuing Coverage Under PEBB Rules

You and your dependents are not allowed to change medical plans at the time benefits are continued on a self-pay basis or when you return to active status. See "If You Want To Change Plans Mid-Year" for specific information.

If you lose eligibility as an active employee, you may continue PEBB medical coverage at the group rate by self-paying premiums for a maximum of 29 months (part-time faculty may self-pay between periods of active employment for up to 18 months) if you're:

- On approved leave without pay;
- Laid off because of a reduction in force;
- Receiving time-loss benefits under Workers' Compensation;
- Awaiting hearing for a dismissal action; or
- Applying for disability retirement.

This 29 months will be reduced by the number of self-pay months allowed under COBRA and the FMLA.

If you revert to your previously held position and do not regain pay status during the last month of employer contributions, you may continue PEBB medical coverage by self-paying for up to 18 months (29 months in some cases).

If your dependents lose eligibility due to your death, they may continue coverage under a retiree plan if they'll immediately begin receiving a monthly benefit from any state of Washington-sponsored retirement system. Your spouse or qualified same-sex domestic partner may continue medical coverage indefinitely; other dependents may continue medical coverage until they lose eligibility under PEBB rules. Application for surviving dependent coverage must be made within 60 days of your death. A dependent who's not eligible for a monthly retirement pension benefit or lump sum payment (because the monthly pension will be less than $50) is not eligible under a retiree plan but may be eligible for continued coverage under COBRA, as described below.

Each dependent is entitled to make a separate decision to exercise this continuation option under PEBB rules.

Continuing Coverage Under the Federal COBRA Law

Under the federal Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 and its amendments, employers are generally required to offer continuation of health coverage to enrollees who lose eligibility. When a *qualifying event* ends eligibility, be sure to contact your personnel, payroll, or insurance office (or the HCA at 1-800-700-1555) within 60 days for details on the right to COBRA continuation and self-pay rates. You must submit an enrollment form within 60 days of the qualifying event. You are required to pay your own premiums, which begin accruing the first day of the month following the qualifying event.

If you don't notify your personnel, payroll, or insurance office or the HCA, you may lose COBRA continuation privileges and have claims denied retroactively.

Qualifying events that trigger COBRA continuation rights are described below:

- You and your dependents may continue PEBB health coverage for up to 18 consecutive months if the qualifying event is reduction of your work hours or termination of employment (except for discharge due to gross misconduct). A second qualifying event during this 18 months may extend the continuation period for your dependents. If you continue your PEBB coverage under the federal COBRA law after termination of employment or reduction in hours, and are disabled under Title II of the Social Security Act at any time during the first 60 days of COBRA coverage, you can extend the continuation period an additional 11 months for all covered individuals. To qualify for the extended coverage, the HCA must be notified before the end of the initial 18 months of COBRA coverage and within 60 days of the disability determination.
- Your covered spouse or children may continue coverage for up to 36 consecutive months if the qualifying event is:
  - Your death;
  - Divorce;
  - Election of Medicare as your primary payer; or
  - A child's loss of eligibility for dependent coverage.

If you continue coverage under COBRA, you may add eligible dependents according to PEBB rules after the continuation period begins. However, those added dependents are not eligible for further coverage if a second qualifying event occurs.

Continued coverage will end on the last day of the month for which premiums were paid and the first of the following occurs:

- The applicable continuation period expires;
- The next required premium is not paid when due;
- You become covered under another group health plan, unless the new plan contains a preexisting condition exclusion or limit (in that case COBRA coverage stops when the COBRA continuation period ends, or when the preexisting condition no longer applies, whichever is first); or
- The employer terminates group medical coverage.

When continued coverage ends, you may apply for conversion to individual medical coverage, as described below.

Each dependent is entitled to make a separate decision to exercise this COBRA continuation option.

Extension Of Coverage for Covered Dependents Not Eligible for COBRA

The following dependents are eligible for an 18-month extension of coverage if you lose coverage due to one of the following events: (a) reduction of your work hours; (b) termination of employment, except for discharge due to actions defined by the employer as gross misconduct. A second event during this 18-month period may extend the continuation period for dependents up to a total of 36 consecutive months if the event is: (a) your death; (b) termination of a qualified domestic partnership; (c) election of Medicare as your primary medical coverage; or (d) a child's loss of eligibility for dependent coverage.

- Your covered dependents who do not meet PEBB dependent eligibility as defined in WAC 182-12-119
- Qualified domestic partner
- Children eligible through a qualified domestic partnership

When an event ends eligibility for coverage, you must contact your payroll, personnel, insurance office or the HCA at 360-412-4200 within 60 days of the qualifying event for information about the right to an extension of coverage and self-pay premium rates. You are required to pay your own premium,

which begins accruing the first day of the month following the qualifying event. If you have the right to continue group coverage, you must enroll within 60 days of the qualifying event and will be required to pay your own premiums. Failure to notify the payroll, personnel, or insurance office, or the HCA may result in the loss of continuation privileges and retroactive denial of claims.

Converting Your Coverage

You may switch from group medical coverage to an individual conversion plan when you're no longer able to continue PEBB group coverage, or are not eligible for Medicare or other group coverage offering hospital or medical benefits. Evidence of insurability is not required for conversion coverage.

Conversion plans usually cost more than continuing coverage under PEBB or COBRA provisions, and may provide substantially fewer benefits than PEBB coverage. You must apply for conversion coverage within 31 days after your group coverage ends. To obtain details on conversion options, call the HCA at 1-800-700-1555 or 360-412-4200.

Definitions

Allowed Charge(s)

The maximum amount the UMP allows for a specific covered service or supply. For professional services, durable medical equipment, supplies and prostheses, allowed charges are the lesser of the provider's billed charge or:

- For *network* providers (**within and outside of Washington**), the applicable contracted fee schedule amount.
- For *non-network/out-of-network providers* **in Washington State**, the UMP fee schedule amount.
- For *non-network/out-of-network providers* **outside of Washington**, a regionally adjusted charge (defined on page 87).

Note: The UMP fee schedule identifies certain services/procedures that are reimbursed on a case-specific basis. In this instance, the allowed charge may be based on UMP's fee schedule amounts for comparable services/procedures, billed charges (or percent of billed charges), Medicare's fee schedules, rates negotiated by case managers and/or other method(s) at the UMP's discretion.

Allowed charges for services from network hospitals and other facilities are determined by the provider's contract with the UMP, Providence Preferred, or Beech Street. For services from non-network or out-of-network facilities, allowed charges are generally based on the provider's billed charge, unless other arrangements have been made.

Allowed charges for prescription drugs are based on Medco Health's standard reimbursement terms for Select Network pharmacies, unless other contractual arrangements or terms apply.

The UMP fee for drugs and biologicals administered other than orally by a provider is based on 95% of Average Wholesale Price.

The UMP reserves the right to determine the amount payable for any service or supply.

Ambulatory Surgical Center (ASC)

A facility certified by Medicare or accredited by a accreditation organization recognized by the Centers of Medicare & Medicaid Services (such as the Joint Commission on Accreditation of Healthcare Organizations [JCAHO]), that provides services for patients who receive invasive procedures requiring general, spinal, or other major anesthesia. (Examples of invasive procedures are biopsies, cardiac and vascular catheterizations, and endoscopies.) The ASC must be licensed by the state(s) in which it operates, unless that state does not require licensure.

Annual Medical/Surgical Deductible

A dollar amount you must pay each calendar year before the UMP pays medical/surgical benefits. Except for services specifically exempted in the "Summary of Benefits," the first $200 per individual in allowed charges for medical/surgical services (or $600 per family if three or more family members are enrolled on one subscriber's account) apply toward your annual medical/surgical deductible and are your responsibility.

Annual Medical/Surgical Out-of-Pocket Limit

A dollar limit on the enrollee coinsurance and copayments you must pay for medical/surgical services each calendar year. The annual limit on the amount you are required to pay in coinsurance and copayments for medical/surgical services (in addition to your annual medical/surgical deductible) is $1,125 per individual or $2,250 per family. Once you have reached this limit, most claims from network and out-of-network providers are paid at 100% of allowed charges, except as otherwise specified in this *Certificate of Coverage*.

The following services and charges are *not* counted towards your or your family's annual medical/surgical out-of-pocket limit:

- Enrollee coinsurance for non-network provider or facility services
- Reductions in benefits applied for failure to comply with medical review/preauthorization requirements (including case management)
- Out-of-network or non-network provider or facility charges in excess of allowed charges
- Charges beyond benefit maximums/limits, such as for physical therapy or outpatient mental health and chemical dependency treatment
- Annual deductible, copayments, and coinsurance for prescription drugs (retail and mail-order)
- Annual medical/surgical deductible
- Emergency room copayments

Annual Prescription Drug Deductible

A dollar amount you must pay each calendar year before the UMP pays prescription drug benefits. The first $100 per individual in allowed charges for prescription drugs (or $300 per family if three or more family members are enrolled on one subscriber's account) apply toward your annual prescription drug deductible and are your responsibility.

Approved Provider Types (or Approved Provider)

See list on pages 26-28. A category of health care provider approved to deliver services under the UMP. *Approved* providers include network, out-of-network and non-network providers. Some approved provider types, such as massage therapists and mental health counselors, must be network providers for the purpose of UMP coverage.

Brand Name Drug

A particular drug product sold under the proprietary name or trade name selected by the manufacturer.

- Single-source: Brand name drugs for which no generic equivalent is available.
- Multi-source: Brand name drugs for which generic equivalents are available.

Calendar Year

January 1 through December 31.

Coinsurance

The percent of allowed charges that the UMP pays for covered services. See also the definition of enrollee coinsurance (used to refer to the percent you pay or "enrollee cost-share").

Copayment

A dollar amount you pay when receiving specific services, treatment, or supplies, such as inpatient hospitalization in a UMP network facility in Washington and Oregon, emergency room care, or Medco Health Home Delivery (mail-order) drugs.

Custodial/Convalescent Care

Care primarily to assist in activities of daily living, including institutional care primarily to support self-care and provide room and board. Custodial care includes, but is not limited to, help in walking, getting into and out of bed, bathing, dressing, feeding and preparing special diets, and supervising medications that are ordinarily self-administered. The UMP reserves the right to determine which services are custodial/convalescent care.

Domestic Partner

A qualified same-sex domestic partner is one who meets the requirements described on the *Declaration of Marriage/Same-Sex Domestic Partnership* form available from the Health Care Authority

or your agency's personnel, payroll, or insurance office.

Durable Medical Equipment

Equipment that is:

- Designed for prolonged use
- For a specific therapeutic purpose in treating your illness or injury
- Medically necessary
- Prescribed by the attending approved provider
- Primarily and customarily used only for a medical purpose

Emergency

See Medical Emergency.

Enrollee

An employee, retiree, or dependent enrolled in the UMP.

Enrollee Coinsurance

The percentage you are required to pay on claims for which the UMP pays less than 100% of allowed charges.

Experimental or Investigational

A service or supply is experimental or investigational if any of the following statements applies when the service is provided. The service or supply:

- Cannot be legally marketed in the United States without approval of the Food and Drug Administration (FDA), and that approval has not been granted
- Is the subject of a current new drug or new device application on file with the FDA
- Is provided as part of a Phase I or Phase II clinical trial, as the experimental or research arm of a Phase III clinical trial, or in any other manner intended to evaluate safety, toxicity, or efficacy
- Is provided under a written protocol or other document that lists an evaluation of safety, toxicity, or efficacy among its objectives
- Is under continued scientific testing and research concerning safety, toxicity, or efficacy
- Is provided under informed consent documents that describe the service as experimental or investigational, or in other terms that indicate the service is being evaluated for safety, toxicity, or efficacy
- Is unsupported by prevailing opinion among medical experts (as expressed in peer-reviewed literature) as safe, effective, and appropriate for use outside the research setting

In determining whether a service or supply is experimental or investigational, the UMP relies exclusively on the following sources of information:

- The enrollee's medical records
- Written protocol(s) or other document(s) under which the service is provided
- Any consent document(s) the enrollee or enrollee's representative has executed, or will be asked to execute, to receive the service
- Files and records of the Institutional Review Board (IRB) or similar body that approves or reviews research at the institution where the service is provided, and other information concerning the authority or actions of the IRB or similar body
- Up-to-date published peer-reviewed medical literature (as defined on page 86) regarding the service, as applied to the enrollee's illness or injury
- Regulations, records, applications, and any other documents or actions issued by, filed with, or taken by the FDA, Office of Technology Assessment, or other agencies within the U.S. Department of Health and Human Services, or any state agency performing similar functions
- Information the provider has shown proficiency in the procedure, based on experience and satisfactory outcomes in an acceptable number of cases

- Opinions from medical adviser specialists

Explanation of Benefits (EOB)

A detailed account of each claim processed by a medical plan, which is sent to you to describe claim payment or denial.

Family

All eligible family members (subscriber and enrollees) enrolled in a single account.

Fee Schedule

UMP's maximum payment amounts for specific services or supplies. Network providers have agreed to accept these fees as payment in full for services to UMP enrollees. See allowed charge definition for more details.

Formulary

A list of selected prescription medicines that assists the UMP in maintaining quality care while meeting cost-containment objectives for you and the UMP. The formulary is reviewed regularly by an independent group of practicing physicians and pharmacists to help ensure that the content is medically sound and supportive of your health. For single-source brand name medications, enrollee coinsurance percentages and copayment amounts vary depending on whether the drug is listed on the UMP formulary.

Generic Drug

Generic drugs have the same active ingredient as brand name drugs no longer under patent and are usually less expensive. Generic drugs use the official chemical title of a drug or drug ingredients published in the latest edition of a nationally recognized pharmacopoeia or formulary. Some are marketed under an alternate brand name.

Health Care Authority (HCA)

A Washington State agency that administers the following health care programs: Basic Health, Community Health Services, and Public Employees Benefits Board (PEBB). The HCA is also responsible for administering the Uniform Medical Plan, as one of the PEBB medical plan options for public employees and retirees.

Home Health Agency

An agency or organization that provides a program of home health care prescribed by an approved provider type (practicing within the scope of its license as an appropriate provider of home health services) and is Medicare-certified, JCAHO-accredited, or a UMP network provider.

Hospice

A facility that provides short periods of direct or respite care for a terminally ill patient in a home-like setting. This facility may be free-standing or affiliated with a hospital. It must operate as an integral part of the hospice care program, and it must be licensed by the state where services are performed or, if state licensure is not required, Medicare-certified or JCAHO-accredited.

Hospice Care Program

A formal Medicare-certified or JCAHO-accredited program directed by an approved provider to help care for a terminally ill patient. This may be through:

- A centrally administered, medically directed, and nurse-coordinated program that provides a system primarily of home care, uses a hospice team of professional and volunteer workers, and is available 24 hours a day, 7 days a week; or
- Confinement in a facility that operates as an integral part of the program to provide short periods of stay in a home-like setting for direct or respite care.

Hospital

An institution accredited as a hospital under the Hospital Accreditation Program of JCAHO and licensed by the

state where it's located. Any exception to this must be approved by the UMP.

The term hospital does *not* include a convalescent nursing home or institution (or part) that:

- Furnishes primarily domiciliary or custodial care;
- Is operated as a school; or
- Is used principally as a convalescent facility, rest facility, nursing facility, or facility for the aged.

Maintenance Care

Medical services designed to preserve or retain a current level of activity or health. The UMP reserves the right to determine which services constitute maintenance care.

Medical Emergency

The sudden and acute onset of a symptom or symptoms, including severe pain, that would lead a reasonable, prudent layperson to believe:

- A health condition exists requiring immediate medical attention and
- Failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of bodily organs, or would place the person's health in serious jeopardy.

The UMP reserves the right to determine whether the symptoms indicate a medical emergency

Medically Necessary

A service or supply required to diagnose or treat illness or injury that meets all of these criteria:

- Consistent with the symptoms, diagnosis, and treatment of your condition;
- For inpatients, cannot be provided safely on an outpatient basis without adversely affecting your condition or quality of care;
- Generally performed or accepted by the medical or dental profession;
- Not solely for your or your provider's convenience;
- The least costly of alternative levels of adequate, available services or supplies; and
- The most appropriate level of service or type of supply needed for the diagnosis or treatment.

The fact a physician or other provider prescribes, orders, recommends, or approves a service or supply does not, in itself, make it medically necessary.

Services that exceed the UMP preventive care benefit are not considered medically necessary unless there is a sound clinical basis for the test or service.

The UMP may require proof that services and supplies, including court-ordered care, are medically necessary. No UMP benefits will be provided if that proof isn't received or isn't acceptable–or if the UMP determines the service or supply is not medically necessary.

Network Provider(s)

Health care providers that have contracted with the UMP (or are part of a provider network that has contracted with the UMP) to provide services to UMP enrollees at a reduced rate. When you use network providers, you cannot be billed for the difference between the provider's billed charge and the UMP allowed charge.

- For services received in Washington and Idaho counties of Bonner, Kootenai, Latah, and Nez Perce, UMP contracts directly with network providers (except for alternative care providers who contract through Alternáre).
- For services received in Oregon, UMP enrollees have access to network providers through the Providence Preferred Oregon network.
- For services elsewhere in the U.S., UMP enrollees have access to network providers through the Beech Street network. Beech Street discounts are not available when Medicare is the primary coverage.

Non-network Provider(s)

Health care providers who practice within the service area of a network provider but are not contracted with the UMP or another UMP-contracted network (Alternáre, Beech Street, or Providence Preferred), and who do **not** provide services to UMP enrollees at discounted rates.

Normal Benefit

The dollar amount of the benefit UMP would normally pay if no other health plan had the primary responsibility to pay the claim.

Open Enrollment Period

A period defined by the HCA when you have the opportunity to change to another health care plan offered by PEBB for an effective date beginning January 1 of the next year.

Out-of-Network Provider(s)

Health care providers located outside of the U.S. or in geographic areas where there is no access to a network provider, as determined by the UMP.

Over-the-Counter Drugs

Medications available for purchase without a prescription, except as otherwise covered in this *Certificate of Coverage*.

Partial Hospitalization

Ambulatory services provided in a hospital setting which permits the patient to return to his or her residence at night.

PEBB Plan

One of several health insurance plans, including the state's own self-funded preferred provider plan, the UMP, offered through the Public Employees Benefits Board (PEBB) program to public employees and retirees. Benefits and eligibility are designed by the PEBB and administered by the Health Care Authority (HCA) as part of a comprehensive employee/retiree benefits package.

Peer-Reviewed Medical Literature

Scientific studies printed in journals or other publications where original manuscripts are published only after being critically reviewed for scientific accuracy, validity, and reliability by unbiased independent experts. Peer-reviewed medical literature, for example, does not include information from health-related Web sites or in-house publications of pharmaceutical manufacturers.

Plan-Designated Facility

A facility, such as a hospital, which is designated for the performance of a particular service(s) for an enrollee. Coverage for these services is dependent upon use of the designated facility. Such a designation will be made by UMP Medical Review, Case Management, or the UMP Medical Director.

Preauthorization

A request to UMP to approve certain services before they are rendered to the enrollee. Preauthorization is not a guarantee of coverage. Failure to preauthorize certain medical services or drugs could result in denial of the claim. Please see "Medical Review/Preauthorization Requirements" starting on page 28 for medical/surgical services that require preauthorization, and "Prescription Drug Coverage Review and Preauthorization for Selected Drugs" starting on page 30 for medications that require preauthorization.

Primary Payer

The insurance plan required to process the claim first for all expenses allowed under its coverage when an enrollee is covered by more than one group insurance plan.

Professional Services

Non-facility medical/surgical services performed by professional providers such as medical doctors, doctors of osteopathy, naturopathic physicians, and advanced registered nurse practitioners.

Provider

An individual medical professional, hospital, skilled nursing facility, other facility or organization, pharmacy, program, equipment and supply vendor, or other entity that provides care or bills for health care services or products.

Regionally Adjusted Charge

The maximum payment for a specific service or supply allowed under UMP fee schedules, when performed by out-of-network providers and non-network providers outside of Washington. The UMP will establish regionally adjusted charges for each geographic area and service using one of the following:

- Medicare's allowable charge in the geographic region, inflated by a percent determined by the UMP;
- Charges most frequently made by providers with similar professional qualifications for comparable services in the provider's geographic area (based on the 75th percentile of data collected by Ingenix, an organization that maintains the Prevailing Healthcare Charges System);
- Most consistent charge made by an individual provider for a particular service;
- The provider's actual charge after any discounts or reductions; or
- The UMP, Providence Preferred, or Beech Street fee schedule.

The UMP reserves the right to determine the amount payable for any service or supply.

Service Area

The geographic area served by network providers. UMP has contracted with Providence Preferred and Beech Street to extend access to network providers throughout the U.S. However, in some areas services may not be available from network providers and may be paid as out-of-network benefits.

Skilled Nursing Facility

An institution, or part of an institution, that provides skilled nursing care 24 hours a day and is classified as a skilled nursing facility by Medicare. Skilled nursing facilities are not Medicaid-eligible long-term care facilities.

Standard Reference Compendium

Refers to any of these sources:

- The American Hospital Formulary Service Drug Information
- The American Medical Association Drug Evaluation
- The United States Pharmacopoeia Drug Information
- Other authoritative compendia as identified from time to time by the federal Secretary of Health and Human Services

Subscriber

The individual or family member who is the primary certificate holder and UMP enrollee.

Substance Abuse Treatment Facility

An institution (or section) specifically engaged in rehabilitation for alcoholism or drug addiction that meets all of these tests:

- Is licensed by the state;
- Keeps adequate patient records that contain course of treatment, progress, discharge summary, and follow-up programs;
- Provides services, for a fee, to persons receiving alcoholism or drug addiction treatment including room and board as well as 24-hour nursing; and
- Performs the services under full-time supervision of a physician or registered nurse.